

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be filled out by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>66-69501</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66-09501</u>	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>Miss Claire Hooton</u>				2. DATE AND HOUR OF DEATH <u>8:30 a.m. 9/18/66</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Lutheran Hosp of Baltimore MD.</u>				A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>15-36</u> D. STREET ADDRESS (If rural, give location) <u>3611 Forest Park Ave.</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>9-21-1887</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Charles H. Hooton</u>			14. MOTHER'S MAIDEN NAME <u>S. Louise Sawtelle</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>212-03-9467</u>		17. INFORMANT <u>Nephew</u>
18. <u>493X</u> I CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>pneumonia</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 15<sup>th</sup></u> 19 <u>66</u> to <u>Sept. 18<sup>th</sup></u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>Sept. 17<sup>th</sup> 20:00</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. J. Kim</u> M.D.				23B. DATE SIGNED <u>Sept. 18<sup>th</sup> '66</u>	
23C. PHYSICIAN'S NAME (Type) <u>WON JA KIM</u> M.D.				23D. ADDRESS <u>Lutheran Hospital in Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/21/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION <u>Pikesville, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Wm. J. Pickens</u>		25D. ADDRESS <u>Marib + Penn. 21217</u>	

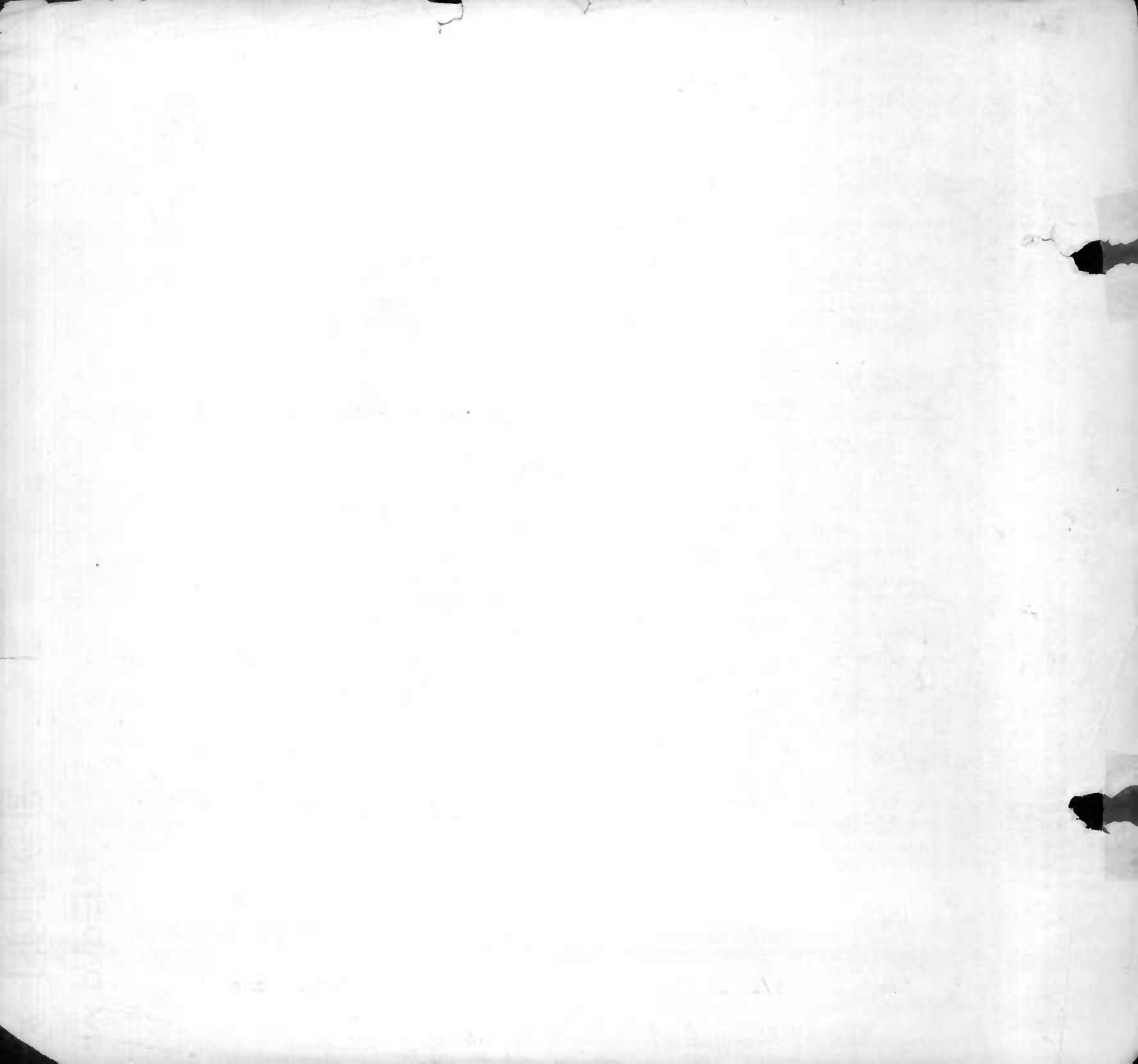




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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09502				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09502	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				LYNN K. ALLRED		9-15-66 10.15 P.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				FLORIDA K-08			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				ORLANDA			
				D. STREET ADDRESS (If rural, give location)			
				3112 JAN DRIVE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
FEMALE	WHITE	MARRIED	12-22-33	32			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife					Texas		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
R.W. KUHLMAN			REGINA SCHMIDT				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No None					Mr. John Allred same address as above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		1 DAY	
ANTECEDENT CAUSES				(B) DUE TO		3 YEARS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
3 9-14-66		TUMOR-CEREBELLUM		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10 Sept 19 66 to 15 Sept 19 66, that (I) (we) last saw the deceased alive on 15 Sept 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
MERWYN BAGAN						9.15.66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
MERWYN BAGAN				THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Removal		9/16/1966				Waco, Texas	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
SEP 20 1966		Robert E. Farley		Wm. J. Fisher & Sons with LPA.			



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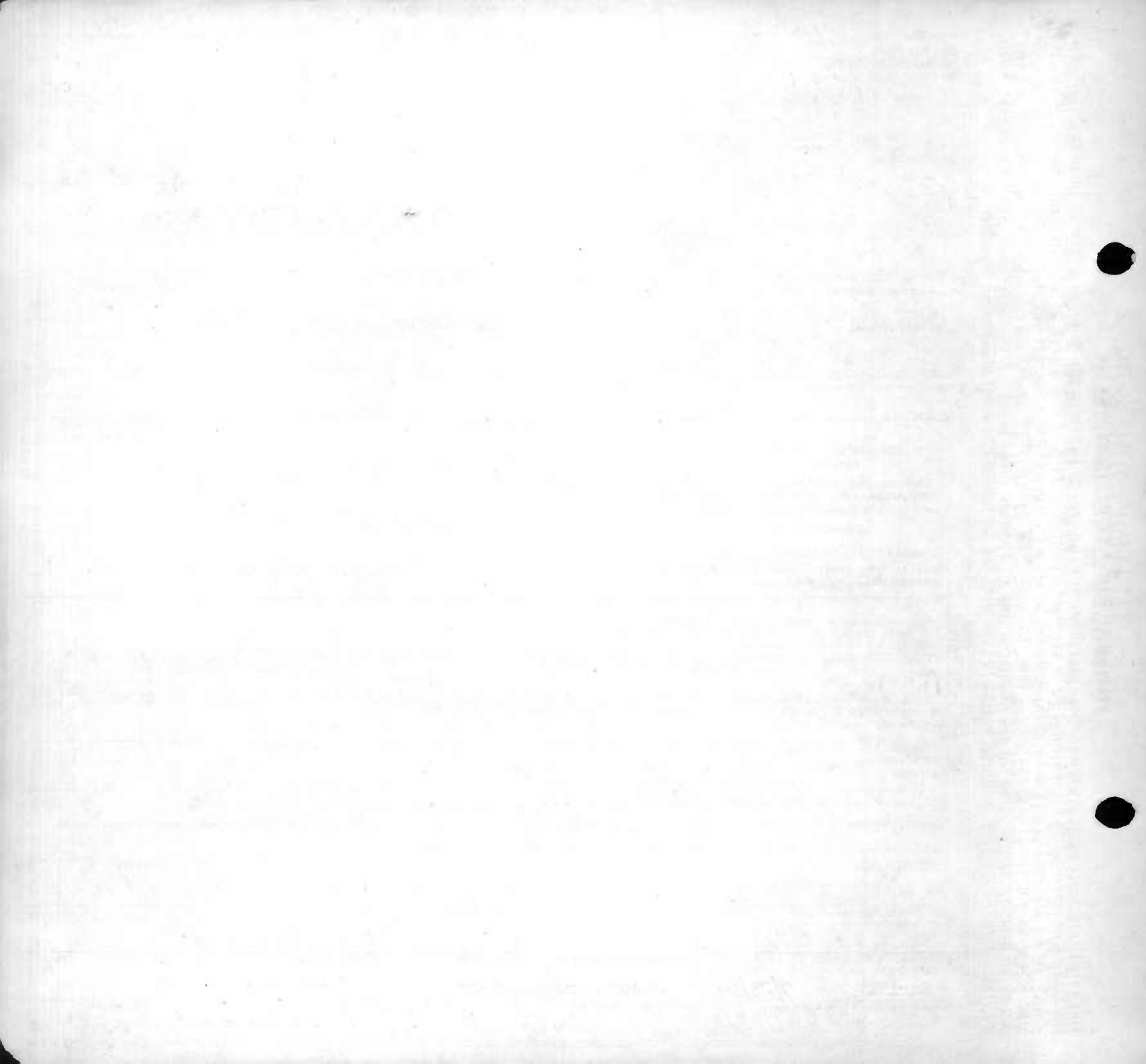
VS 150-REV. 1/1/65



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BIRTH NO. 66 09504		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09504	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Zell, Jerome Joseph		2. DATE AND HOUR OF DEATH Sept. 19, 1966 2:40 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Md. Hosp.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 16-08			
		D. STREET ADDRESS (If rural, give location) 3929 Cranston Ave			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-26-03	9. AGE (In years lost birthday) 62	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man.		10B. KIND OF BUSINESS OR INDUSTRY Cemetery		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Louis Zell		14. MOTHER'S MAIDEN NAME Mary Miller	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. }		17. INFORMANT Pt's chart	
18. 177X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Uremia DUE TO		2 weeks (approx)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Ureteral Obstruction DUE TO		?	
		(C) Adenocarcinoma of prostate 2 metastases		14 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1965 to Sept 1966, that (I) (we) last saw the deceased alive on Sept 19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis C. Breschi		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept 19, 1966	
23C. PHYSICIAN'S NAME (Type) Louis C. Breschi		23D. ADDRESS M.D. University Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/23/66	24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR Wm. J. Dickner Sons, Inc. North & Penna. Aves.	



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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09505	
BIRTH NO. 66 09505		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>William Caleb Scott</b>	
2. DATE AND HOUR OF DEATH <b>9-17-66 3<sup>30</sup> P. M.</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>27-13</b> D. STREET ADDRESS (If rural, give location) <b>811 St. Georges Rd</b>		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>811 St. Georges Road Baltimore, Maryland 21210</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Nov 11, 1873</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MANUFACTURER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND BISCUIT CO</b>	9. AGE (In years last birthday) <b>92</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>ELIJAH COUBOURN SCOTT</b>		14. MOTHER'S MAIDEN NAME <b>MARY TILGHMAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-3944</b>	
17. INFORMANT <b>JOHN M. SCOTT</b>		ADDRESS <b>8 LONGWOOD RD., BALTIMORE 10, MD</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Chronic Pyelonephritis</b> INTERVAL BETWEEN ONSET AND DEATH <b>?</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Uremia</b> <b>1 Week</b>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Benign Prostatic Hyperplasia</b> <b>8 Years</b>		21. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b> 20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NO</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NO</b>		21D. TIME OF INJURY (APPROX.) <b>NO</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>NO</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>October 19 58</b> to <b>September 17 19 66</b> , that (I) (we) last saw the deceased alive on <b>Sept. 17 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>William G. Helfrich</b>		23B. DATE SIGNED <b>Sept 17, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>William G. Helfrich</b>		23D. ADDRESS <b>5006 Roland Ave., Balto. 10 Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9/19/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 20 1966</b>	25B. NAME OF REGISTRAR <b>Robert E. Farley</b>	25C. FUNERAL DIRECTOR <b>Wm. J. Dickner &amp; Sons Inc.</b>	
ADDRESS <b>North &amp; Penna Ave</b>			



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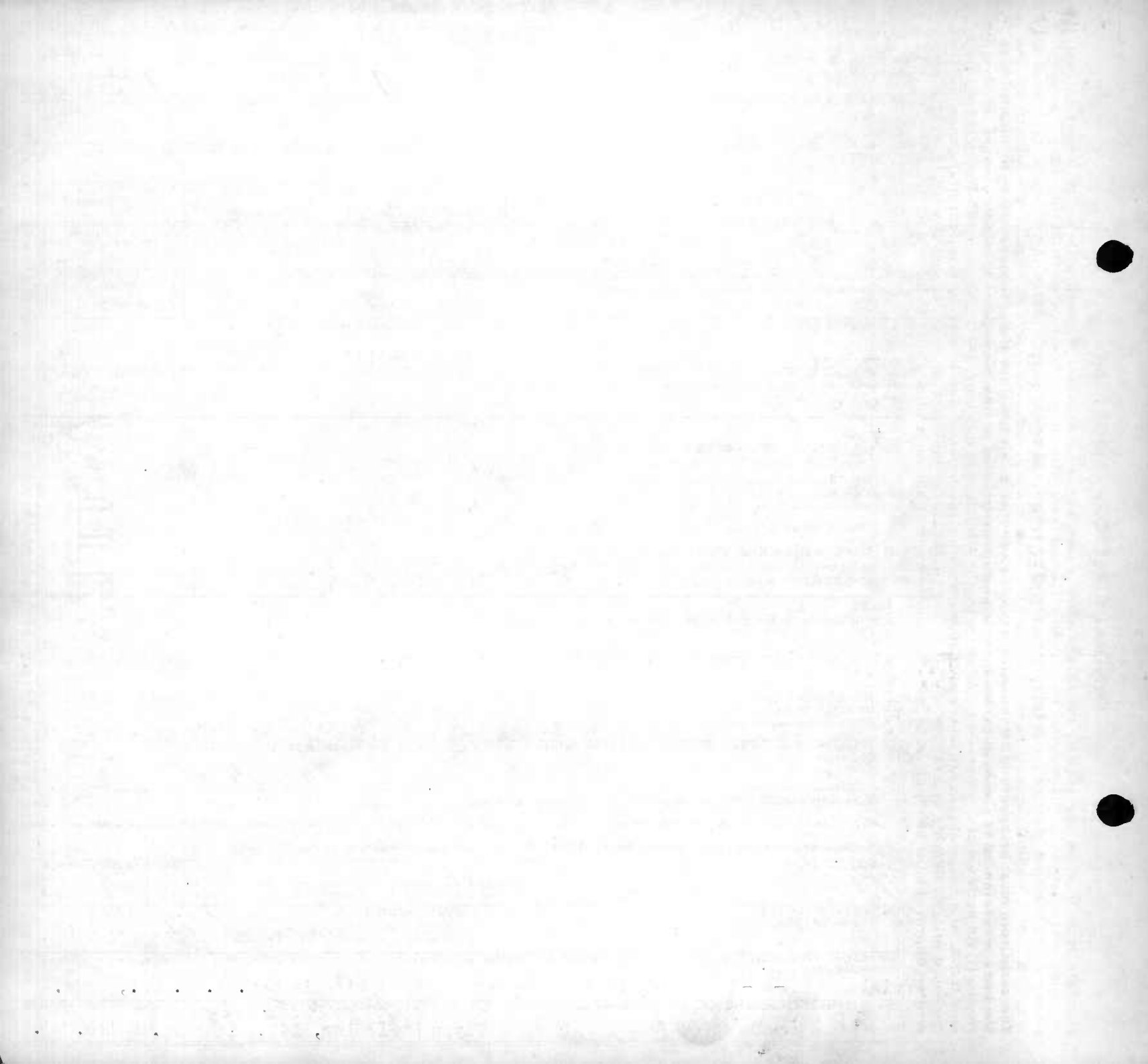
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BIRTH NO. 66 09506				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09506	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Mary Mayo</i>				2. DATE AND HOUR OF DEATH <i>17 Sept 66</i> <i>1:35</i> <i>A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>13-01</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>MARY LAND GENERAL Hosp</i> <i>Baltimore Md</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
				D. STREET ADDRESS (If rural, give location) <i>LAKE DRIVE NURSING HOME</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>4-29-87</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Henry Meyd</i>				14. MOTHER'S MAIDEN NAME <i>Anna Aymold</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. <i>07051</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Aspiration of Vomitus (probable)</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Small Bowel Obst</i> <i>Chronic Dehydration</i> <i>CHF</i>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <i>Lake Dr. Nursing Home</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Lake Dr. Nursing Home</i>			
21D. TIME OF INJURY (APPROX.) <i>Sept 16 66 9:50 PM</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>Apparately Fell</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>16 Sept</i> <i>1966</i> to <i>17 Sept</i> <i>1966</i> , that (I) <del>we</del> lost saw the deceased alive on <i>17 Sept</i> <i>1966</i> and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <i>Michael B. Flynn</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>17 Sept 66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Michael B. Flynn</i>				23D. ADDRESS <i>Maryland General Hosp</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-20-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Cross Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Ritchie Hwy. A. A. Co., Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Feltman</i>		25C. FUNERAL DIRECTOR <i>Ray C. Fleming</i>		ADDRESS <i>Flynn &amp; Fleming, 1422 Light St. Balto. Md.</i>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

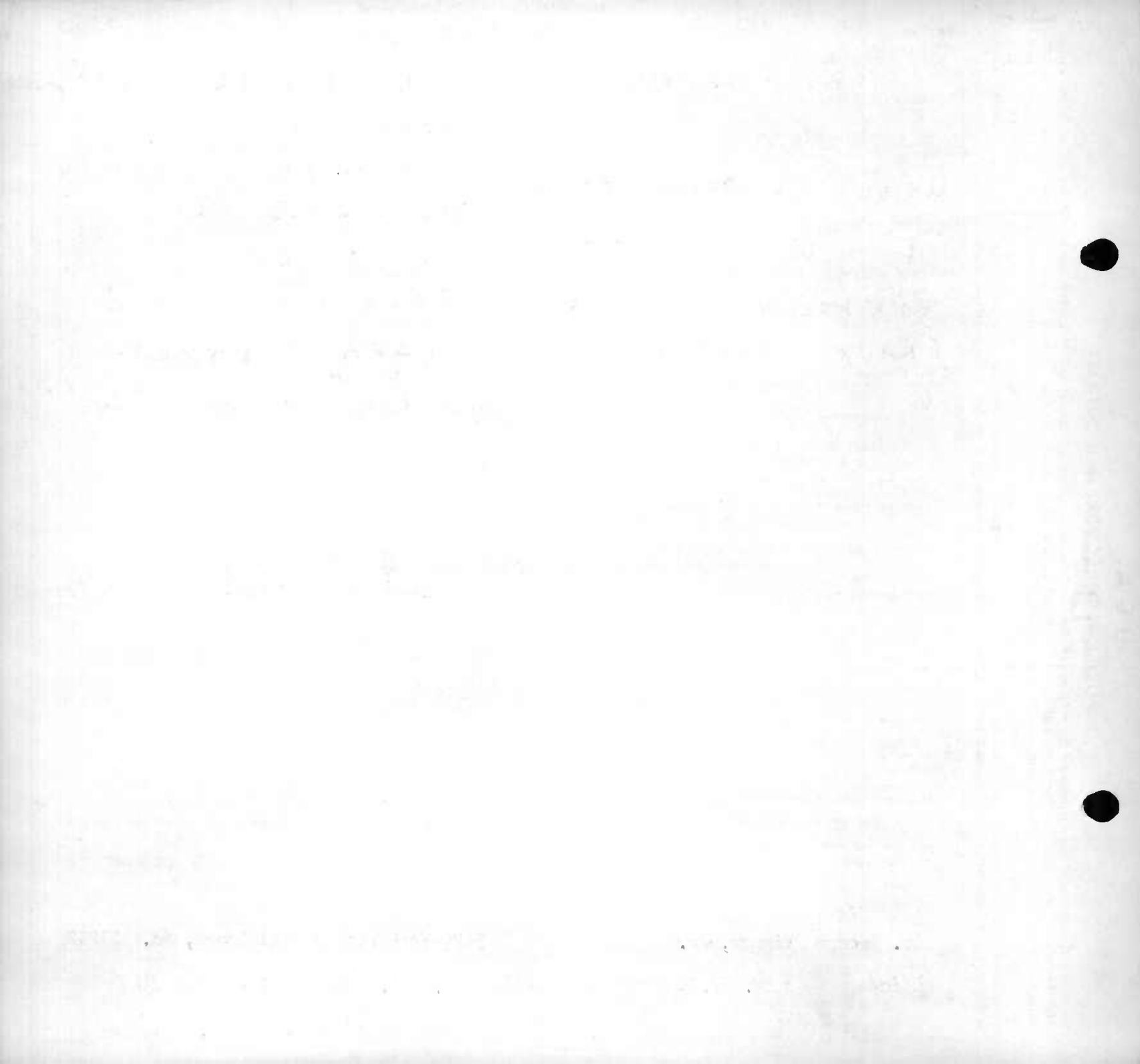
BIRTH NO. 66 09507		BALTIMORE CITY HEALTH DEPARTMENT		86 09507	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>SMITH, COLEMAN FRANCIS</b>			2. DATE AND HOUR OF DEATH <b>9-19-66 9:15 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b> (If not in hospital or institution, give street address or location)			A. STATE <b>MARYLAND</b>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>PASADENA</b>			D. STREET ADDRESS (If rural, give location) <b>110 APPEAN WAY</b>		
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	
8. DATE OF BIRTH <b>12-29-90</b>		9. AGE (In years last birthday) <b>75</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>JOHN SMITH</b>		14. MOTHER'S MAIDEN NAME <b>MARY SMITH</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216 10 6639</b>		17. INFORMANT ADDRESS <b>HOSPITAL SLIP -ST. AGNES HOSPITAL</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute peritonitis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1-2 days</b>			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Perforated peptic ulcer 1-2 days</b> <b>Strangulated Hernia (Hernia) 4 days</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPTEMBER 16 1966</b> to <b>SEPTEMBER 19 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>SEPTEMBER 19, 1966</b> and that <input checked="" type="checkbox"/> (our) opinion of death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <b>Carl Matthey</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>CARL MATTHEY</b>				23D. ADDRESS <b>CATON AND WILKENS AVE. BALTIMORE MD</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>9/23/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State) <b>Baltimore</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 20 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>137 Potomac Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09508		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09508	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) MRS. MARGUERITE CLARA WEAVER				9-17-66 6:15 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		A. STATE MARYLAND		B. COUNTY Baltimore	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21204			
		D. STREET ADDRESS (If rural, give location) 1713 ROLAND AVE. 5300			
5. SEX F	6. RACE W	7. <del>MARRIED, NEVER MARRIED</del> WIDOWED, <del>DIVORCED</del> (Specify)	8. DATE OF BIRTH 7-16-03	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOK KEEPER		10B. KIND OF BUSINESS OR INDUSTRY GROCERY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME FRANK HAUSER		14. MOTHER'S MAIDEN NAME CLARA REJZEK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO.		17. INFORMANT DAUGHTER MRS. KATHLEEN BRITT	
18. 603X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) pulmonary edema. (B) Gastrointestinal bleeding (C) Absence of Rt. Kidney and gall-bladder		INTERVAL BETWEEN ONSET AND DEATH 4. K. Bin	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPT. 12, 1966 to SEPT. 15, 1966, that (I) (we) last saw the deceased alive on SEPT. 12, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. George E. Finner, Jr.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Dr. George E. Finner, Jr.		23D. ADDRESS 5828 York Road, Baltimore, Md. 21212			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 21, 1966		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Cem.	
24D. LOCATION (City, town, or county) (State) Cockeysville, Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland	





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPT.		66 09509		86 09509	
BIRTH NO.		66 09509		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ROSSI, Thomas		September 18, 1966 11:30 am M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 1-02	
Baltimore City Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		516 S. Potomac Street #24	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
male	white	widowed	7/20/81	85 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Cement Finisher		Balto. Gas & Elec. Co.		Italy	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		Emidio Rossi		Concetta ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		212-05-5092		Dominick Rossi, above, son	
18. 443X1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Aggravated cardiac decompensation</i>			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (the hospital) attended the deceased from 9/18/66 to 9/18/66, that (I) (we) last saw the deceased alive on 9/29/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
<i>Joseph R. Liberto</i>				9/19/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Joseph Liberto		3508 Bank Street			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	9/21/66	Holy Redeemer Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
SEP 20 1966	<i>Robert E. Schumaker</i>	Schimunek Funeral Home, Inc.		3331 Enoch's Lane #13	

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*Handwritten text, possibly "The end of the world"*

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 09510		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09510	
1. NAME OF DECEASED (Type or Print) <b>MARTHA K. COFFMAN</b>			2. DATE AND HOUR OF DEATH <b>9-16-66</b> <b>8</b> <b>P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MD. GENERAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>4-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO</b> D. STREET ADDRESS (If rural, give location) <b>322 N. PACA ST.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>1-18-84</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H/W</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>HAGERSTOWN, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>William H KENDALL</b>			14. MOTHER'S MAIDEN NAME <b>?? Ida Rowland</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-12-8065</b>	17. INFORMANT ADDRESS <b>DAUGHTER &amp; GRANDSON - CHART</b>		
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <b>CEREBRAL <del>THROMBOSIS</del> <del>ASCVD</del> <del>PNEUMONIA</del></b>		INTERVAL BETWEEN ONSET AND DEATH <b>7-28-9-16</b>
			(A) <b>ASCVD</b> DUE TO <b>PNEUMONIA</b>		<b>7-28-9-16</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-28-1966</b> to <b>9-16-1966</b> , that (I) (we) last saw the deceased alive on <b>8-16-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ronald Goldner</b>				23B. DATE SIGNED <b>Sept 16, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>RONALD GOLDNER M.D.</b>			23D. ADDRESS <b>MD. GENERAL HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/20/1966</b>	24C. NAME of CEMETERY or CREMATORY <b>Rose Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 20 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Andrew K. Coffman, Hagerstown, Md.</b>	



B-346

66 09511

BALTIMORE CITY HEALTH DEPARTMENT

66 09511

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Frances Butler 2. DATE AND HOUR PRONOUNCED DEAD 9/19/66 1:03 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-16

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2415 W. Cold Spring La.

5. SEX female 6. RACE colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married 8. DATE OF BIRTH 4/26/19 9. AGE (in years last birthday) 47 10. UNDER 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Pa. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jas. Morris 14. MOTHER'S MAIDEN NAME Diane Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. 218-22-8434 17. INFORMANT ADDRESS Chas. Butler 2415 Cold Spring La.

18. CAUSE OF DEATH 19. INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Septicemia following acute pyelonephritis of a congenital hydronephrosis. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER DATE SIGNED 9/19/66

23A. BURIAL CREMATION, REMOVAL (Specify) 23B. DATE 9/23/66 23C. NAME OF CEMETERY or CREMATORY Pleasant Rest 23D. LOCATION (City, town, or county) (State) Towson, Balto. Co. Md.

24A. DATE REC'D BY HEALTH DEPT. 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR 24D. ADDRESS

WALLEY FOMGIE

W. F. FOMGIE

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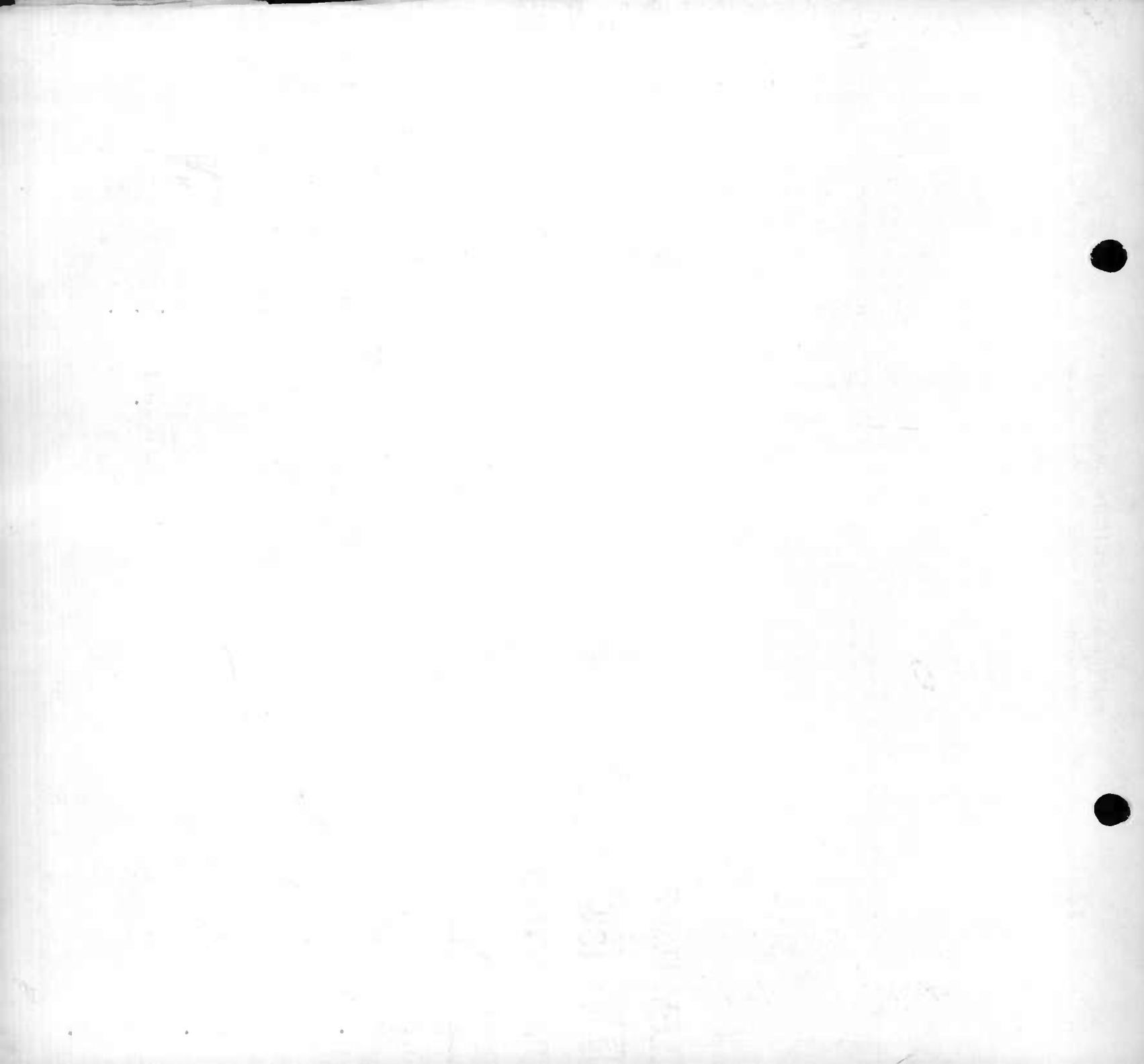


# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 09512					Registered No. 66 09512				
M.E. CASE NO.					Baltimore City Health Department				
1. NAME OF DECEASED (Type or Print) MORRIS MITCHELL					2. DATE AND HOUR OF DEATH 9-19-66 9 45 P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1210 SHORT COURT				
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-24-33	9. AGE (In years last birthday) 32	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN MITCHELL					14. MOTHER'S MAIDEN NAME TRUE MILLER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Rose Mitchell 1210 Short Ct.				ADDRESS
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Malignant hypertension INTERVAL BETWEEN ONSET AND DEATH 5 yrs					19. MEDICAL CERTIFICATION II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		21G. DATE SIGNED 9/19/66		21H. DATE SIGNED			
22. I certify that (I) (this hospital) attended the deceased from 9/17 1966 to 9/19 1966, that (I) (we) last saw the deceased alive on 9/19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					23A. SIGNATURE Sherrard L. Hayes				
23B. PHYSICIAN'S NAME (Type) SHERRARD L. HAYES					23C. ADDRESS 1533 E. Monument St.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9/25/66		24C. NAME OF CEMETERY or CREMATORY Beechwood		24D. LOCATION (City, town, or county) (State) North Carolina			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS Charles A. Rice 661 W. Barre St.			





# BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

William T. Mosely

2. DATE AND HOUR PRONOUNCED DEAD

9/19/66 12:20 p. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

11-9-66

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3115 Clifton Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11/15/10

9. AGE (In years last birthday)

55

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Mosley

14. MOTHER'S MAIDEN NAME

Henrietta

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Ruth Mosley 370 Manhattan Ave. Apt. 2K N.Y.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH  
Rupture of Duodenal Peptic Ulcer  
Peritonitis

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Rupture of gastric peptic ulcer

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/19/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/23/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION (City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 20 1966

Charles A. Rice 661 W. Barre St.

VALLEY FORGE

EXHIBIT CONTENT

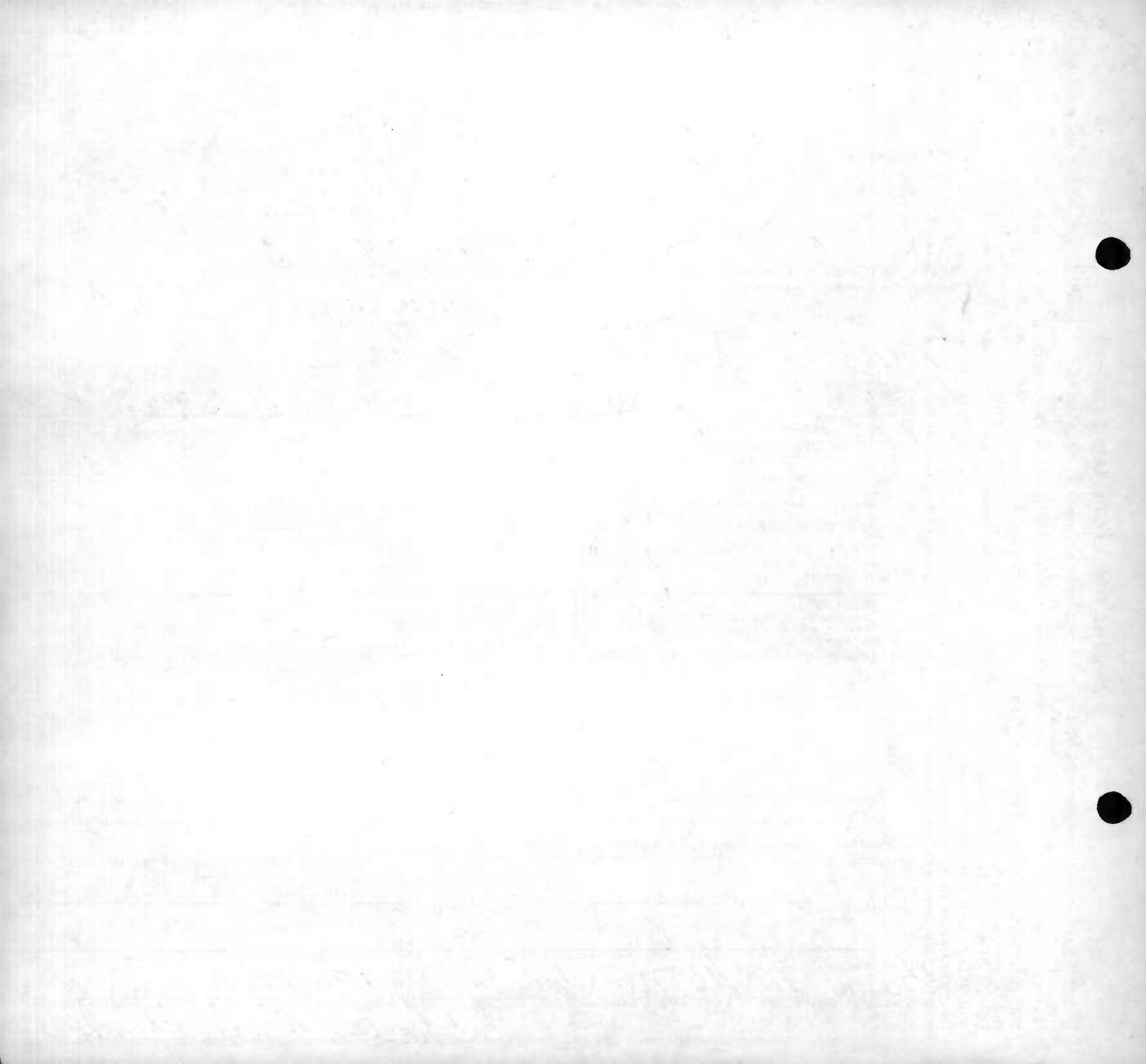
USA

11-9-66

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 09514		66 09514		66 09514	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Milton Williams			9-20-66 10:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Mercy Hospital			Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore 10-02		
			D. STREET ADDRESS (If rural, give location)		
			809 McKim St		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months: Days: Hours: Min.
M	C	Married	7/12/34	32	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Marie Williams			Zelda		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		286-30844		Magdaline Williams 809 McKim St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Interval BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Intra Cerebral Hemorrhage 4 days		
19A. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
2			Yes		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-16-66 to 9-20-66, that (I) (we) last saw the deceased alive on 9-20-66 and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Frank L. Barham				9-20-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
FRANK L. BARHAM		Mercy Hospital Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/24/66		Mt Calvary	
24D. LOCATION (City, town, or county) (State)		25A. DATE RECEIVED BY HEALTH DEPT.			
Brooklyn Md		SEP 20 1966			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
Robert E. Tabor		Charles A. Rice		6614 Boone St	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09515	
BIRTH NO. 66 09515		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type in print) <b>CHARLES HENSON</b>		2. DATE AND HOUR OF DEATH <b>SEPT 18, 1966 9 40 PM M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>		A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>6012 BELCROVE RD</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>7-7-94</b>	9. AGE (In years, lost birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND U.S.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>JOHN HENSON</b>			14. MOTHER'S MAIDEN NAME <b>MARTHA GAMBLER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Annie Henson - 6012 Belcove Rd.</b>	
18. <b>4-22-1 I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <b>ASCVD</b>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) _____			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>UREMIA &amp; DEHYDRATION</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>SEPT 17 1966</b> to <b>SEPT 18 1966</b> , that (I) <del>was</del> last saw the deceased alive on <b>SEPT 18 1966</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>view</del> view the body after death.					
23A. SIGNATURE <b>Dr. Matthew Kaufman</b> M.D.				23B. DATE SIGNED <b>9-18-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>no permission for auto psy given</b>				23D. ADDRESS <b>UNIV. HOSP.</b> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-23-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Carver Mem. Pk. Laurel Md</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. STATE <b>MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 20 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Burnell B. Oden - Balto. Md</b>	

PH 2

James H. Brown - was ill

James H. Brown - was ill  
James H. Brown - was ill



SAB-47-48-85

M-600

66 09516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

66 09516

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MIRTH NO.		66 09516		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		66 09516			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
				Lennie Moore				9-18-66 9:30 AM.			
3. PLACE OF DEATH IN				BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
								A. STATE B. COUNTY			
								Maryland			
FULL NAME OF HOSPITAL OR INSTITUTION				(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Baltimore			
D. STREET ADDRESS (If rural, give location)								2015 Lafayette Street 21217			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months; Days; 11. Under 24 Hrs. Hours; Min.	
Male		Negro				10-20-06		60			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Laborer								Durham Co. N.C.			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
USA				Samuel Moore				Dora Curtis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
No				191-03-4721				Rosea Moore - Durham, N.C.			
								Records: BCM-4940 Eastern Avenue 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) Cerebral Artery Thrombosis							
ANTECEDENT CAUSES				(B) Atherosclerosis							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)							
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Chronic alcoholism; Meningo Tumor infection			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2				YES		YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (A) (this hospital) attended the deceased from		8-18-1966 to		9-18-1966		that (I) (we) last saw the deceased alive on		9-18-1966		and that in (A) (our) opinion death occurred on the date	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
Richard L. Bishop		9-18-66		Richard L. Bishop		4940 Eastern Avenue, Baltimore, Maryland					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		9-23-66		Buttrick Cemetery		Transville Co. N.C.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
SEP 20 1966		Robert E. Taylor		Purnell B. Oden - Balto. Md.							

10

10-20-06

Dunham Co. N.C. 522A

Dora Curtis

Dunham Co. N.C.

191-03-1211

Journal M. 1000

Journal M. 1000

Laboratory

No

Journal 1903-04 Dunham Co. N.C.

Dunham Co. N.C.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 09517</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09517</b>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>FRANK Westcott</b>			2. DATE AND HOUR OF DEATH <b>9/18/66 1:05 P.M.</b>		
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>44</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>4350 South BALTO. Gen. Hosp</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>316 First Ave S.W. - 0200</b>		
			D. STREET ADDRESS (If rural, give location) <b>Glen Burnie, Md</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>1-3-96</b>	9. AGE (In years last birthday) <b>70</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mold Maker - Ret.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Carr Lowry Glass</b>		11. BIRTHPLACE (State or foreign country) <b>n.g.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>		13. FATHER'S NAME <b>Samuel Westcott</b>			
14. MOTHER'S MAIDEN NAME <b>Carrie Camm</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW1</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Margaret Westcott, same as 4</b>			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Adeno carcinoma of the colon w/ metastasis (carcinomatous)</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Primary ca of colon generalized adeno sclerosis</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/17/66</b> 19 <b>66</b> to <b>9/18</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/18 - 11 AM</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. G. Arellano</b>				23B. DATE SIGNED <b>9/18/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERTO G. ARELLANO</b>				23D. ADDRESS <b>SOUTH BALT. GEN. HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>21 Sept. 66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 20 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Talley</b>		25C. FUNERAL DIRECTOR <b>St. Joseph's Funeral Home</b>			

Ms. A. 9.2.11

Ms. A. 9.2.11

Ms. A. 9.2.11

Ms. A. 9.2.11

Ms. A. 9.2.11

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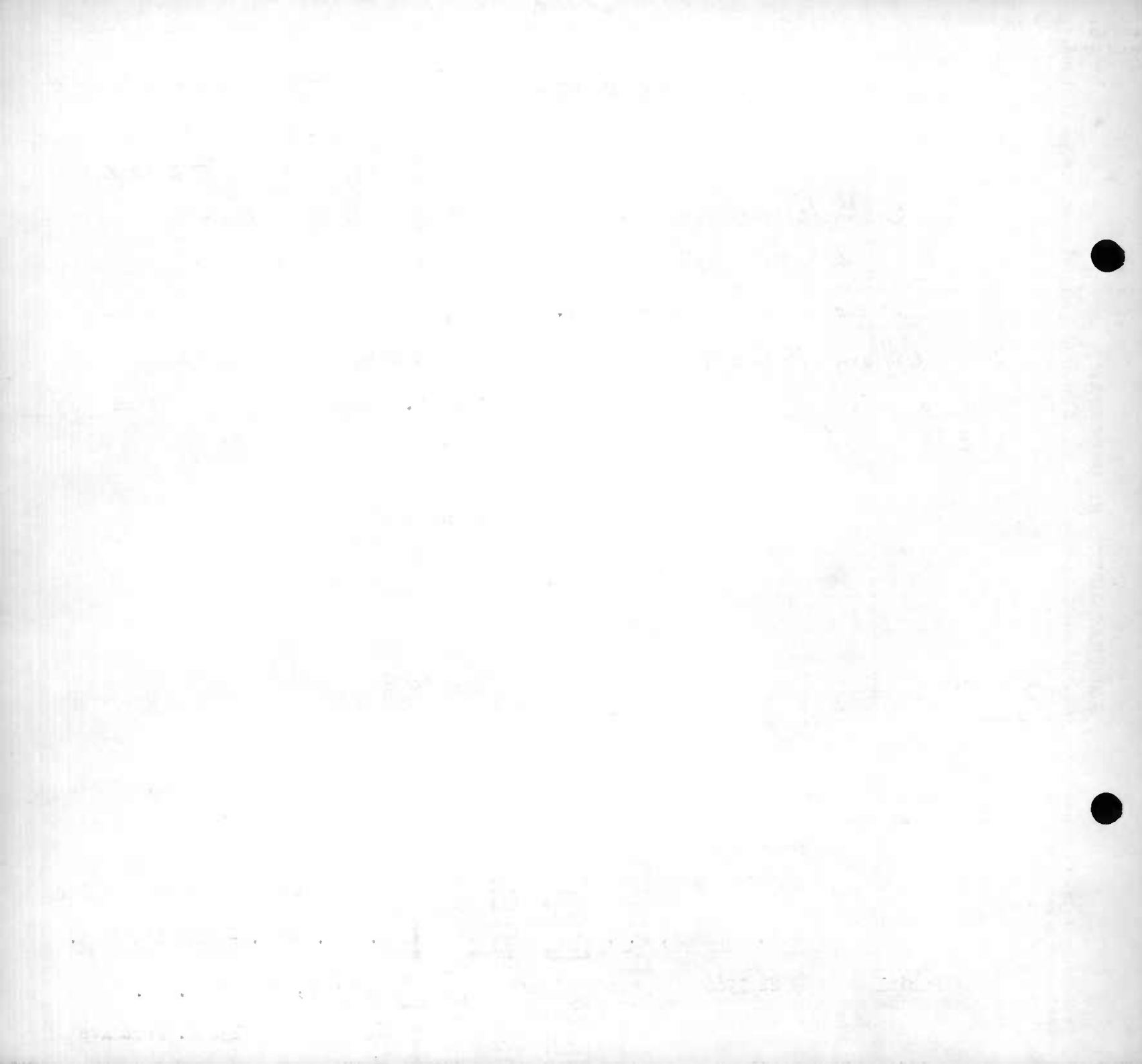
Ms. A. 9.2.11

Ms. A. 9.2.11

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09518		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09518	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>Frank George</i>		
2. DATE AND HOUR OF DEATH <i>9-19-1966 11:05 A. M.</i>			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balto</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21227</i>		
D. STREET ADDRESS (If rural, give location) <i>3124 Bero Road. 5300</i>			FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>South Baltimore General Hosp.</i>		
5. SEX <i>M.</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>10-24-1903</i>	9. AGE (In years last birthday) <i>62</i>	(If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Paper Box Co.</i>		
11. BIRTHPLACE (State or foreign country) <i>Ky.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		
13. FATHER'S NAME <i>William H. George</i>			14. MOTHER'S MAIDEN NAME <i>Emma Musie</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>James D. George</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Cardiac Failure</i>			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <i>9-14-66</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>BRONCHOGENIC CA</i>		20A. AUTOPSY? (Yes or No) <i>YES.</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <del>this</del> (this hospital) attended the deceased from <i>9-6</i> 19 <i>66</i> to <i>9-19</i> 19 <i>66</i> , that <del>we</del> (we) lost saw the deceased alive on <i>9-19</i> 19 <i>66</i> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jose B. Corvera</i>				23B. DATE SIGNED <i>9-19-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOSE B. CORVERA, M.D.</i>				23D. ADDRESS <i>South Balto. Gen. Hosp. - 1213 Light St.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9 22 1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge</i>	
24D. LOCATION (City, town, or county) (State) <i>Dorsey, Howard Co. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor, MA</i>		25C. FUNERAL DIRECTOR <i>Mc Cully</i>			
25D. ADDRESS <i>130 E. Fort Ave</i>					

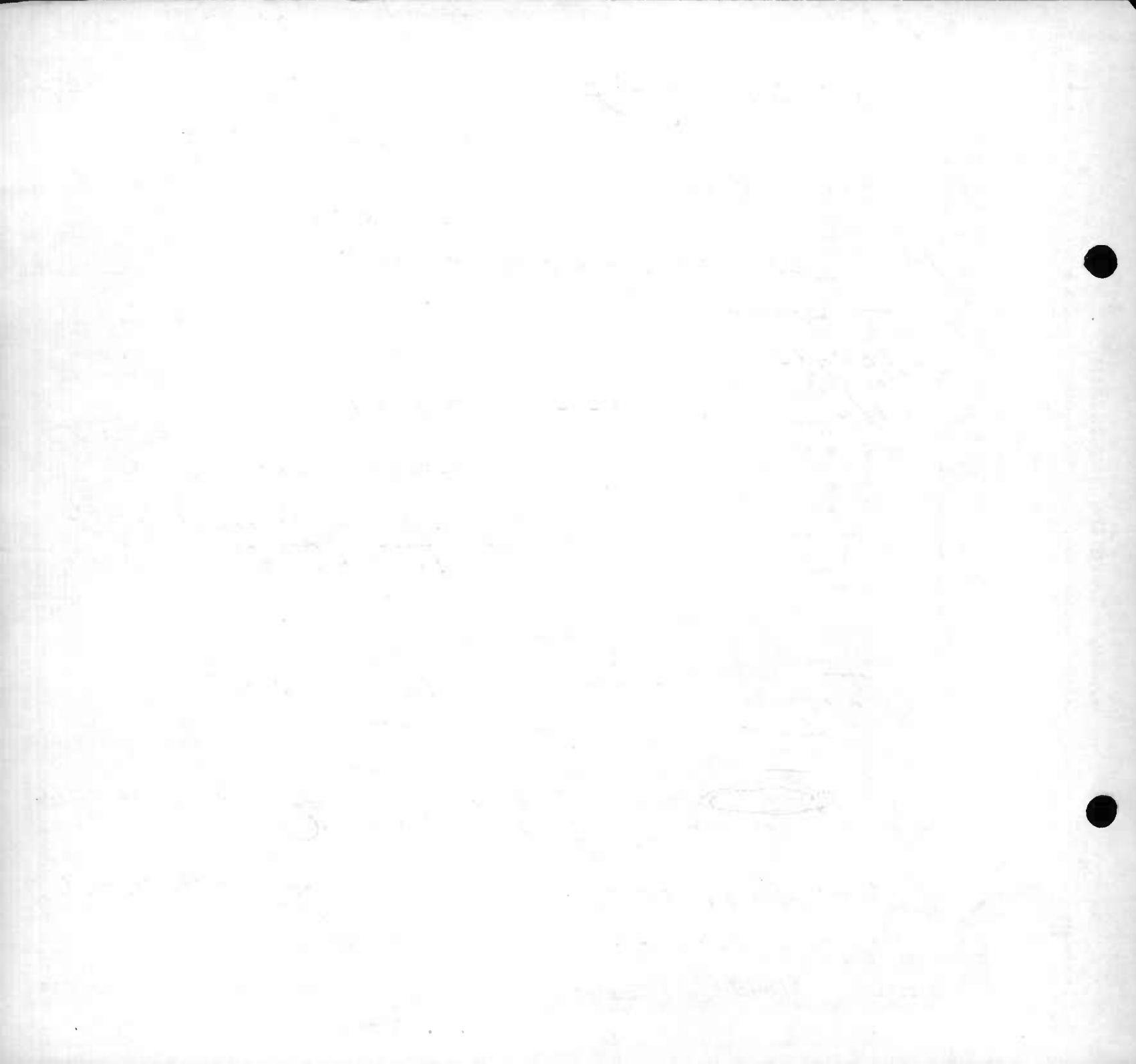


# FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department				Registered No. 66 09519	
BIRTH NO. <b>W 300</b>		CERTIFICATE OF DEATH			
M.E. CASE NO. <b>66 09519</b>					
1. NAME OF DECEASED (Type or Print) <b>WOODY WADE</b>		2. DATE AND HOUR OF DEATH <b>9-16-66 130 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSP.</b>		A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>FALLSTON</b>			
		D. STREET ADDRESS (If rural, give location) <b>HESS RD.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>6-15-45</b>	9. AGE (In years last birthday) <b>21</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
13. FATHER'S NAME <b>LEONARD Wade</b>		14. MOTHER'S MAIDEN NAME <b>Ruby Cox</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-46-2063</b>		17. INFORMANT <b>CHART</b>	
18. <b>152.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY ARREST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>METASTATIC CA. PROBABLY 6 MOS. FROM SMALL BOWEL</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>0</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <b>NO</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>8-18</b> 19 <b>66</b> to <b>9-16</b> 19 <b>66</b> . that (I) (we) last saw the deceased alive on <b>9-16</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Alvin Schachter</b> M.D. PHYSICIAN'S NAME (Type) <b>ALVIN SCHACHTER</b>		23B. DATE SIGNED <b>9-16-66</b>		23C. ADDRESS <b>SINAI HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/20/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Creston</b>	
24D. LOCATION (City, town, or county) (State) <b>West Jefferson North Carolina</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 20 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. J...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>J. F. Eline &amp; Sons Reisterstown, Md.</b>			

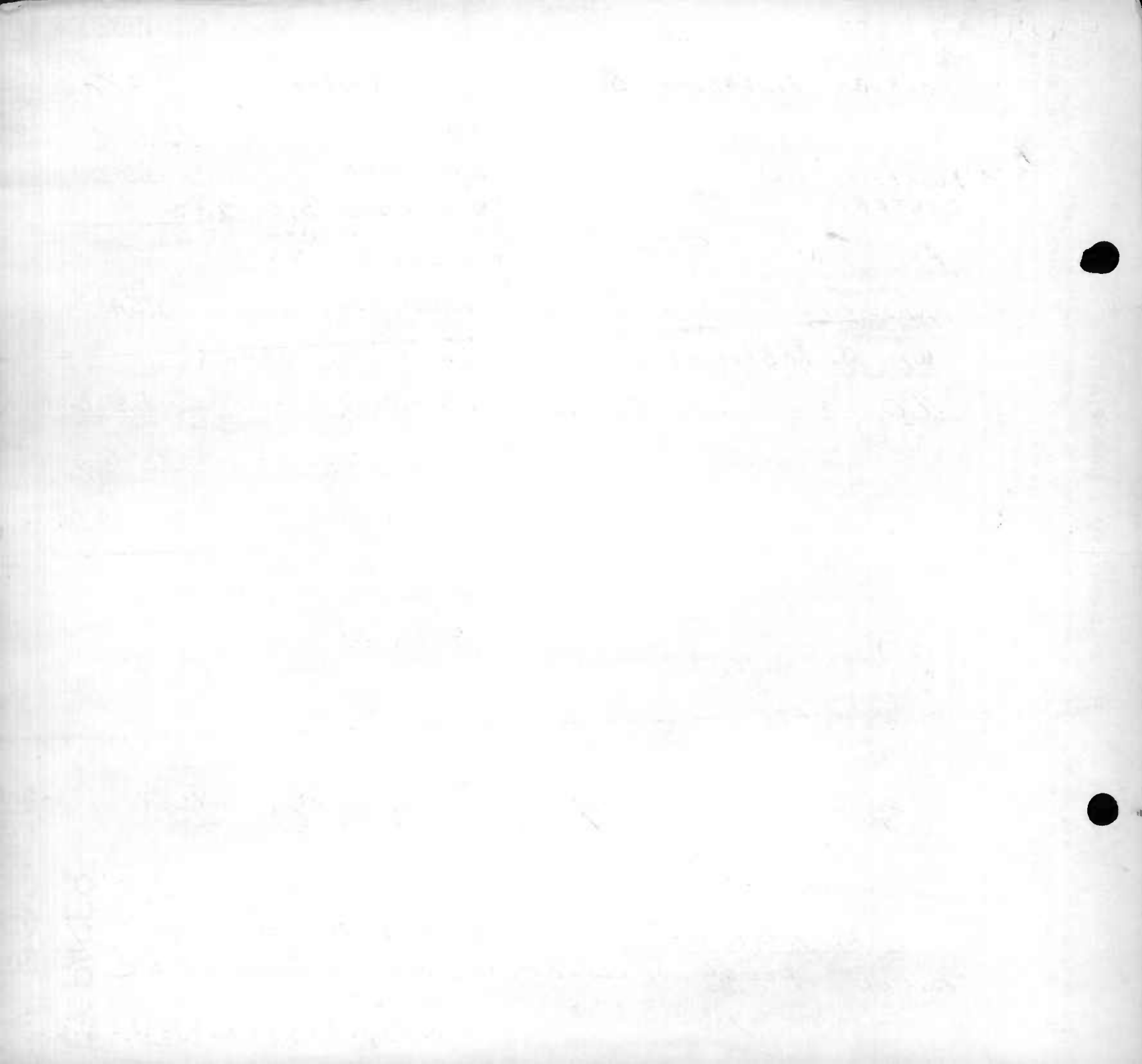




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09520	
BIRTH NO. 66 09520		X		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>HORNER, ELIZABETH D.</b>		2. DATE AND HOUR OF DEATH <b>9-19-66</b> <b>2 55 A</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Bolton Hill Convalescent Center</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltr</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>3016 - 2nd Ave. 21234</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. <del>MARRIED</del> NEVER MARRIED <del>WIDOWED</del> DIVORCED (specify)	8. DATE OF BIRTH <b>Dec 25, 1883</b>	9. AGE (In years last birthday) <b>83</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>WM. J. BABINGTON</b>		14. MOTHER'S MAIDEN NAME <b>ELLA M. CLARK</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-03 6245</b>		17. INFORMANT <b>WM. F. HORNER</b> ADDRESS <b>3016 2nd AVE. BALTIMORE</b>	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <b>Recurrent C.V. A</b> DUE TO (B) <b>Hypertension</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>several years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ASCVD</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-19-66</b> to <b>9-19-66</b> that (I) (we) last saw the deceased alive on <b>9-19-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>H. Nakazawa</b>				23B. DATE SIGNED <b>9-19-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>H. NAKAZAWA</b>		23D. ADDRESS M.D. <b>3350 Wilkes Ave Balto 29</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-22-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT OLIVET CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>WASHINGTON D.C.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 20 1966</b>			
25B. NAME OF REGISTRAR <b>E. J. Taylor</b>		25C. FUNERAL DIRECTOR <b>W.W. Chambers &amp; Co. Wash. D.C.</b>			



66 09521

BALTIMORE CITY HEALTH DEPARTMENT

66 09521

BIRTH NO. 66-10734 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Deanna Moore

2. DATE AND HOUR PRONOUNCED DEAD

9/19/66

7:05 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

850 Franklinton Rd.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Child

8. DATE OF BIRTH

8/9/66

9. AGE (In years  
lost birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Day Hours Min.

1 21

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Child

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Raymond Moore

14. MOTHER'S MAIDEN NAME

Daisy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

M's Daisy Moore 850 Franklin Town Rd

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Interstitial pneumonitis (SDII)  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/20/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9/23/66

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cemetry

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 20 1966

Robert E. Janney, M.D.

Adolphus Halstead 1206 W North Ave

WALLACE COMPANY

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<b>CERTIFICATE OF DEATH</b> BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09522</b>	
BIRTH NO. <b>66 09522</b>		M. <b>66 09522</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>12:50 AM 9/19/66</b>	
1. NAME OF DECEASED (Type or Print) <b>Hutchins, Lillian W.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> <b>20-01</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE MARYLAND 21224</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1907 W. Franklin St.-21223</b>	
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>9/9/31</b>
9. AGE (In years, lost birthday) <b>35</b>		If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>na</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM KEENE</b>		14. MOTHER'S MAIDEN NAME <b>LILLIAN Wicks</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224</b>		ADDRESS	
18. <b>002, 11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac arrest</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>70 min</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>cor pulmonale</b> <b>2° pulmonary hce</b>		DUE TO <b>5 years</b> <b>10 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>YES</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/18</b> 19 <b>66</b> to <b>9/19</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/19</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>E. P. Wilkinson</b>		23B. DATE SIGNED <b>9/19/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>C. P. Wilkinson</b>		23D. ADDRESS <b>Baltimore City Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Sept 23, 1966</b>	24C. NAME OF CEMETERY or CREMATORY <b>Balto. National Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 20 1966</b>	25B. NAME OF REGISTRAR <b>Robert E. Farley</b>	25C. FUNERAL DIRECTOR <b>Williams Funeral Home 319 N. Scholcher St.</b>	

22

1914

W. H. C.

W. H. C.



66 09523

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09523

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

William McKinney

2. DATE AND HOUR PRONOUNCED DEAD

9/16/66 2:05 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

7-04

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1011 Lamont Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

June 28 1912

9. AGE (In years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Chester, Delaware

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles L. McKinney

MOTHER'S MAIDEN NAME

Edna Grant

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Shirley Jones 2249 E Chase St

18. E981X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Massive internal Bleeding  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Gunshot wound of chest  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

1400 Blk. Tin Pan Alley

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

9 16 66 12:45 a.m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot several times

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/16/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9-20-66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cat

23D. LOCATION

(City, town, or county)

Brooklyn Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 21 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Eloyd W. Wilson 1000 Broadway Ave

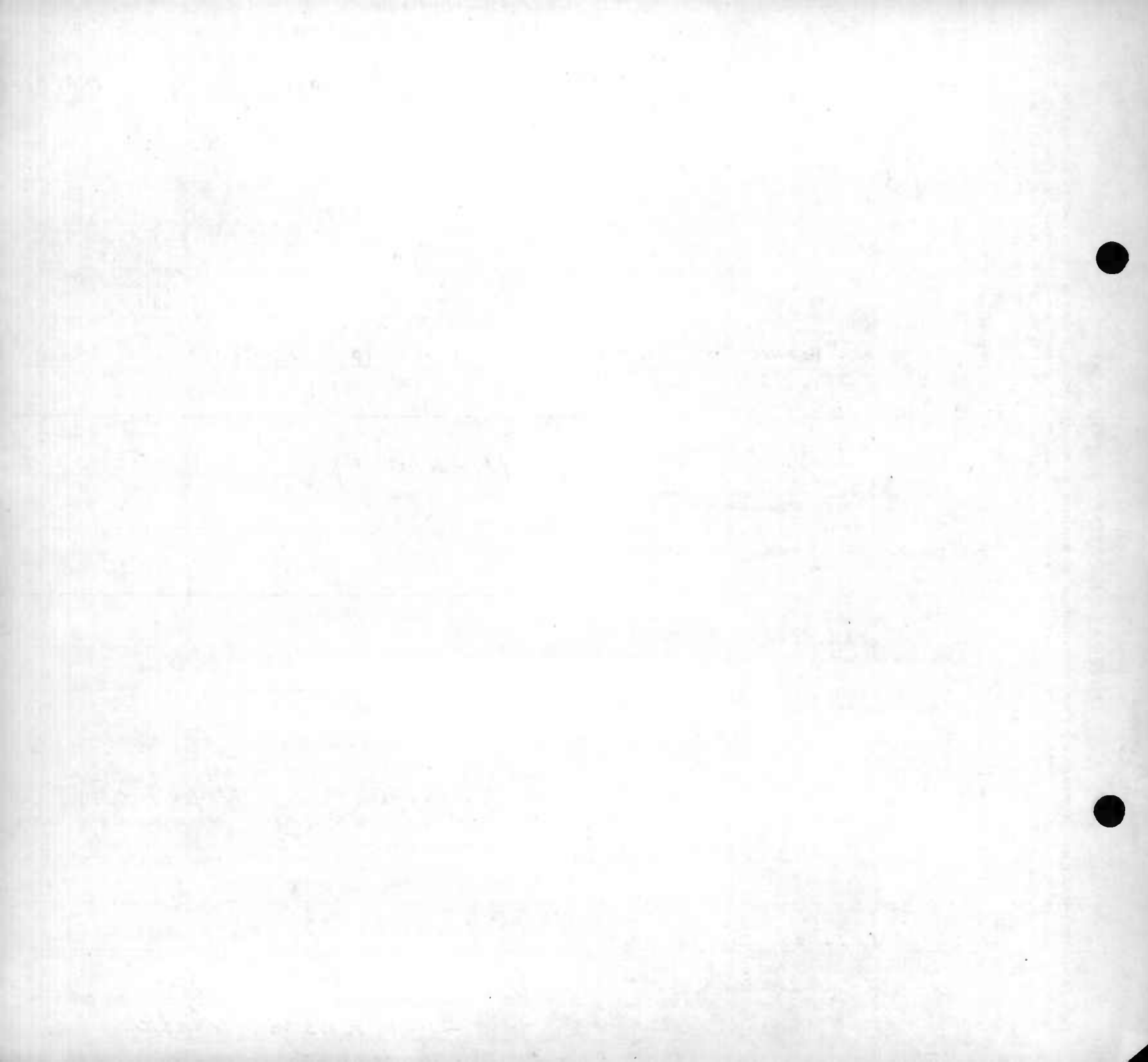
ADDRESS

MAILED 1947

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

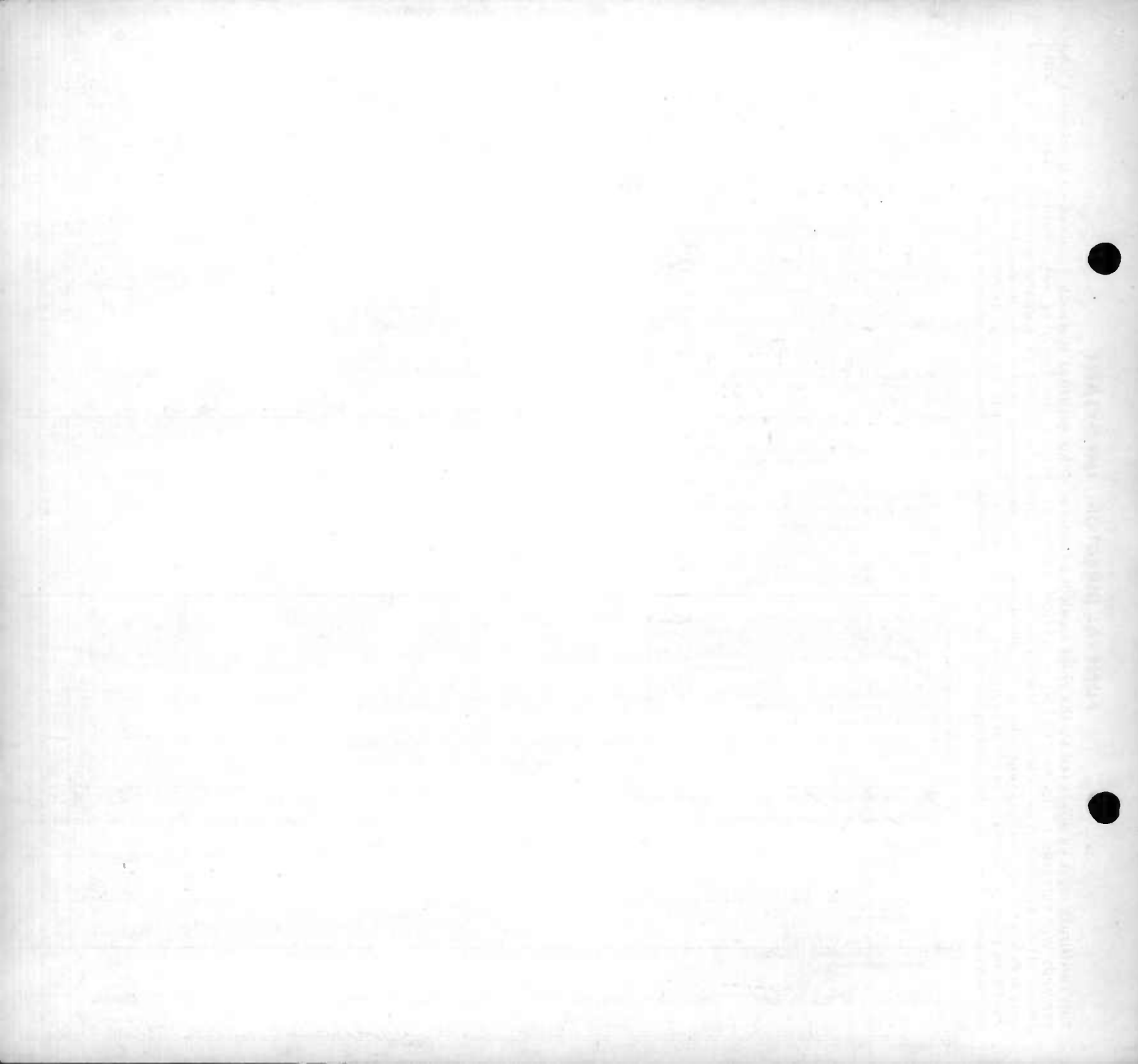
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 68 09524		REGISTERED NO. 68 09524	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				BARRY L. McClellan		9/19/66 11:45 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				MD		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
UNIVERSITY HOSPITAL				BALTO		20-04	
BALTO, MD				D. STREET ADDRESS (If rural, give location)		2232 BUSA ST	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
M		W		In fact		9/19/66	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
5		15		BALTO MD		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
THOMAS WILLIAMS				MATIE McCLELLAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						Elliot S. Tokar	
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No							
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9/19/66 - 6:30 PM to 9/19/66 11:45 AM that (I) (we) last saw the deceased alive on 9/19/66 11:45 AM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Elliot S. Tokar				9/19/66		UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial				9-21-66		Mt Auburn Cem	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 21 1966				Robert E. Farkner		Elroy Wilson - Balto.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09525		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09525	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Bessie Mae Keaton</i>		2. DATE AND HOUR OF DEATH <i>1 40 AM Sept 20, 1966 M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University of Maryland Hospital</i>		A. STATE B. COUNTY <i>Bar-Wil-Ba Nursing Home 27-15</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>2101 W. Cold Spring Ln. Balto. Md</i>			
		D. STREET ADDRESS (If rural, give location) <i>B 2101 W. Cold Spring Ln.</i>			
5. SEX <i>F</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widow</i>	8. DATE OF BIRTH <i>10/31/01</i>	9. AGE (In years last birthday) <i>64</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>	
13. FATHER'S NAME <i>George Brown (dec.)</i>		14. MOTHER'S MAIDEN NAME <i>Narcissie Johnson (dec)</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Narcissie Watkins Pasadena Md</i>	
18. <i>332 X R 260 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>Cerebral Vascular Thrombosis, Multiple</i> (B) DUE TO <i>Cerebral Arteriosclerosis</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>Yrs + Days</i> <i>Yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Diabetes Mellitus</i>		<i>Yrs.</i>	
19A. DATE OF OPERATION <i>9-17-66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>W</i> (this hospital) attended the deceased from <i>9-17-66</i> to <i>9-20-66</i> , that <i>W</i> (we) last saw the deceased alive on <i>9-19-66</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>W</i> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William R. Law</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9-20-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>William R. Law</i>		23D. ADDRESS <i>UNIVERSITY HOSP BALTO. MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>9-24-66</i>	24C. NAME OF CEMETERY or CREMATORY <i>Carver Cent</i>		24D. LOCATION (City, town, or county) (State) <i>Lanham Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 21 1966</i>		25B. NAME OF REGISTRAR <i>John E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Shoyl Wilson 1000 Brantley Ave</i>	



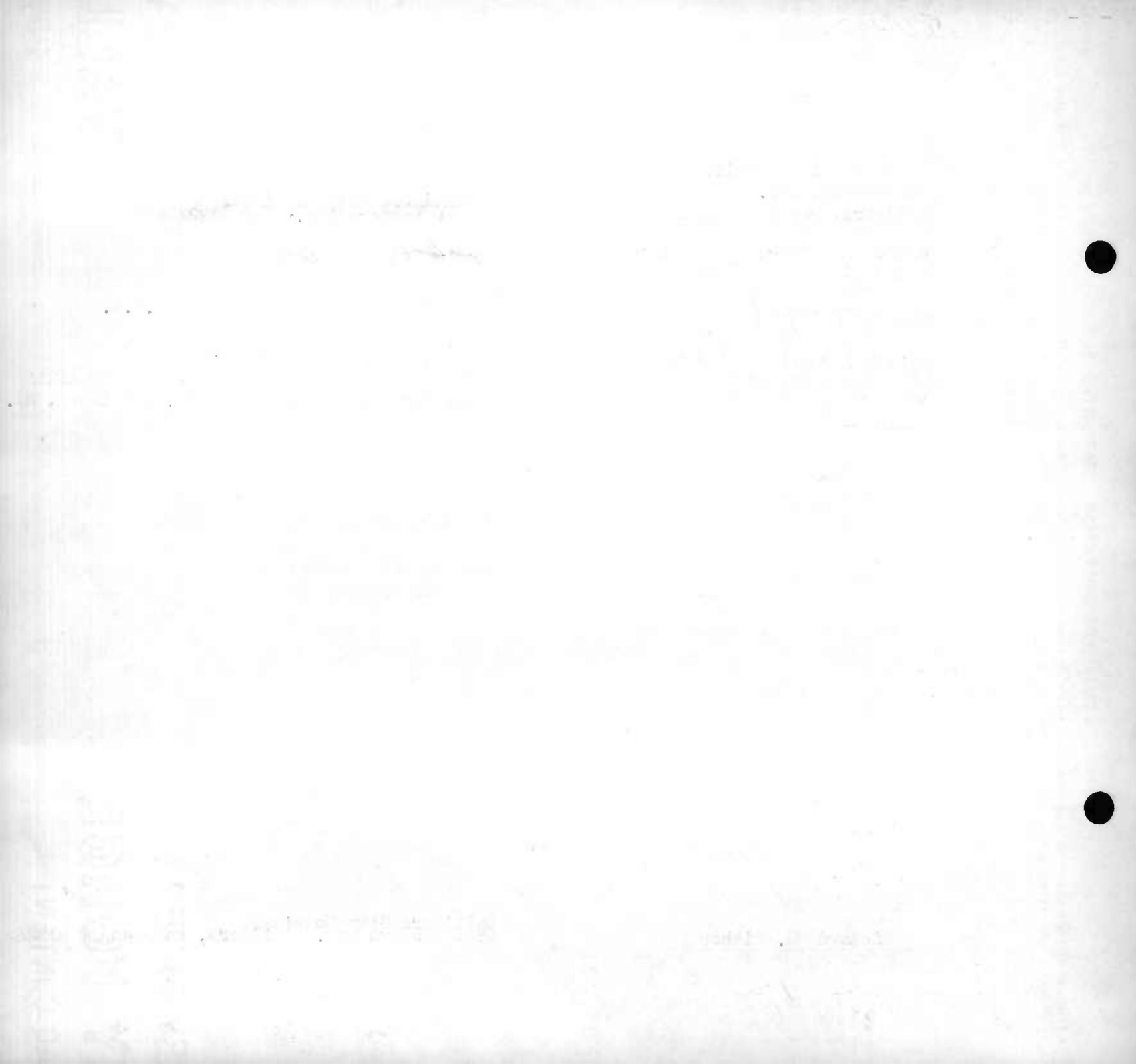


## FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>66 09526</b>		CERTIFICATE OF DEATH		Registered No. <b>66 09526</b>	
1. NAME OF DECEASED (Type or Print) <b>Nona Adams (Ramsey)</b>			2. DATE AND HOUR OF DEATH <b>9-18-66 6:40 P M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-12</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>Baltimore City Hospitals 4940 Eastern Ave. # 21224</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>6-6-1902</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Richard Ramsey</b>			
14. MOTHER'S MAIDEN NAME <b>Mitilda Ramsey</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>BCH; Records 4940 Eastern Ave. Baltimore, Md.</b>			
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Anteriorly Congestive Heart Failure</b>		CAUSE OF DEATH (A) <b>Anteriorly Congestive Heart Failure</b> DUE TO (B) <b>Anteriorly Congestive Heart Failure</b> DUE TO (C) <b>Diffuse Atherosclerosis</b>			
19. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>10-18</b> 19 <b>66</b> to <b>9-18</b> 19 <b>66</b> , that (2) (we) last saw the deceased alive on <b>9-18</b> 19 <b>66</b> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.					
23A. SIGNATURE <b>Richard G. Bishop</b> M.D.				23B. DATE SIGNED <b>9-18-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Richard G. Bishop</b>				23D. ADDRESS M.D. <b>Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-22-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Not Antler Cmt</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Shoy Wilson and Beauty Co</b>			
25D. ADDRESS					

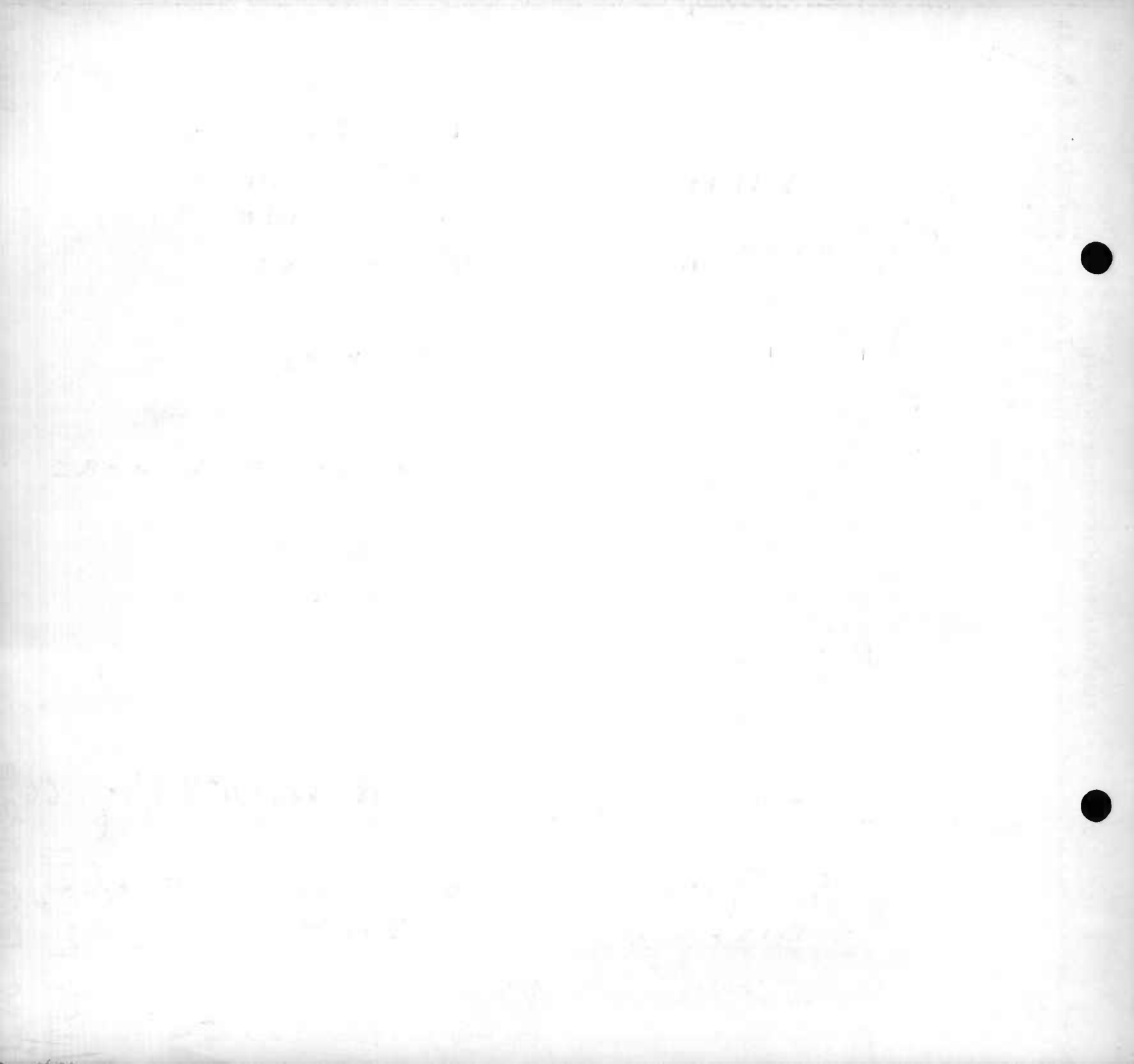




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 09527	
BIRTH NO. 66 09527		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MAGGIE CROELL		2. DATE AND HOUR OF DEATH 9/18/66 11 AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location) J H H		A. STATE Md B. COUNTY BALT MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT BALTIMORE 10-02	
D. STREET ADDRESS 807 N EDEN ST		5. SEX FEMALE		6. RACE COLORED		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	
8. DATE OF BIRTH 6/22/98		9. AGE (In years last birthday) 68		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME EDDIE RADDICK		14. MOTHER'S MAIDEN NAME GERTRUDE Riddick	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-5697		17. INFORMANT James Turner 1842 E Chase Street		ADDRESS	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) 9 Intracerebral bleed (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 6 HRS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Notes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3 AM 9/18 1966 to 11 AM 9/18 1966, that (I) (we) last saw the deceased alive on 9/18 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE S. Mishkin				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/18/66	
23C. PHYSICIAN'S NAME (Type) S. MISHKIN				23D. ADDRESS J H H;			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-21-66		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cent		24D. LOCATION (City, town, or county) (State) Brooklyn Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Cheryl Wilson 1000 Broadway Ave			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09528		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09528	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>STELLA SIMPSON</b>		2. DATE AND HOUR OF DEATH <b>9-19-66 4 55 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL BALTIMORE MARYLAND</b>		A. STATE <b>VIRGINIA</b> B. COUNTY <b>V-43</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>SMALLTOWN, VA.</b>			
		D. STREET ADDRESS (If rural, give location) <b>WILLIS WHARF</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>1-27-04</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>NANCY MORRIS</b>	
				ADDRESS <b>8 WIMPOLE DR. YORK PA</b>	
18. <b>416 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		(A) <b>Bronchopneumonia</b> DUE TO		<b>4 days</b>	
		(B) <b>Congestive heart failure</b> DUE TO		<b>3 weeks</b>	
		(C) <b>Rheumatic heart disease</b>		<b>Unknown</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2 NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (If (this hospital) attended the deceased from <b>9-1-</b> 19 <b>66</b> to <b>9-19</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>9-19</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Timothy Kenney Gray</b> M.D.				23B. DATE SIGNED <b>9-19-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>TIMOTHY KENNEY GRAY</b> M.D.				23D. ADDRESS <b>University of Maryland Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/23/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Belle Haven Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Belle Haven, Va.</b>					
25A. DATE RECEIVED BY HEALTH DEPT. <b>SEP 21 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 09529					CERTIFICATE OF DEATH		Registered No. 66 09529		
1. NAME OF DECEASED (Type or Print) <u>DALE, ALLAN</u>					2. DATE AND HOUR OF DEATH <u>19 SEPT 66</u> <u>12:15 P.</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNION MEMORIAL HOSP.</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>27-13</u> <u>729 DEEPPENE ROAD</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1/30/1877</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXX Auditor</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>DENMARK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>ALLAN DAHL</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>217-05-1276</u>		17. INFORMANT ADDRESS <u>Mrs. Sigrid Dale 729 Deepdene Rd. Balt. Md.</u>				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute MI</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH <u>RS</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>9/18/66</u> 19 <u>66</u> to <u>9/19</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/19</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Sidney E. Kirkley</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>19 Sept 66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. SIDNEY E. KIRKLEY</u>					23D. NAME OF REGISTRAR <u>THE UNION MEMORIAL HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>9/22/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1966</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Inc. Baltimore, Md.</u>			

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BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 66 09530

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Joseph Kelly

2. DATE AND HOUR PRONOUNCED DEAD

9/19/66 10:25 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1616 W. Baltimore St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1616 W. Baltimore St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

11/11/09

9. AGE (In years last birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James F. Kelly

14. MOTHER'S MAIDEN NAME

Marie E. O'Farrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

2/27/52 - 7/1/55

16. SOCIAL SECURITY NO.

218-07-1672

17. INFORMANT

ADDRESS

Joseph Kelly Jr. 5017 Schaub Ave Balt. Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis and emphysema  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/19/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/22/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Catonsville, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 21 1966

Robert E. Farley, M.D.

Wm. Cook-Brooks Inc. Baltimore, Md.

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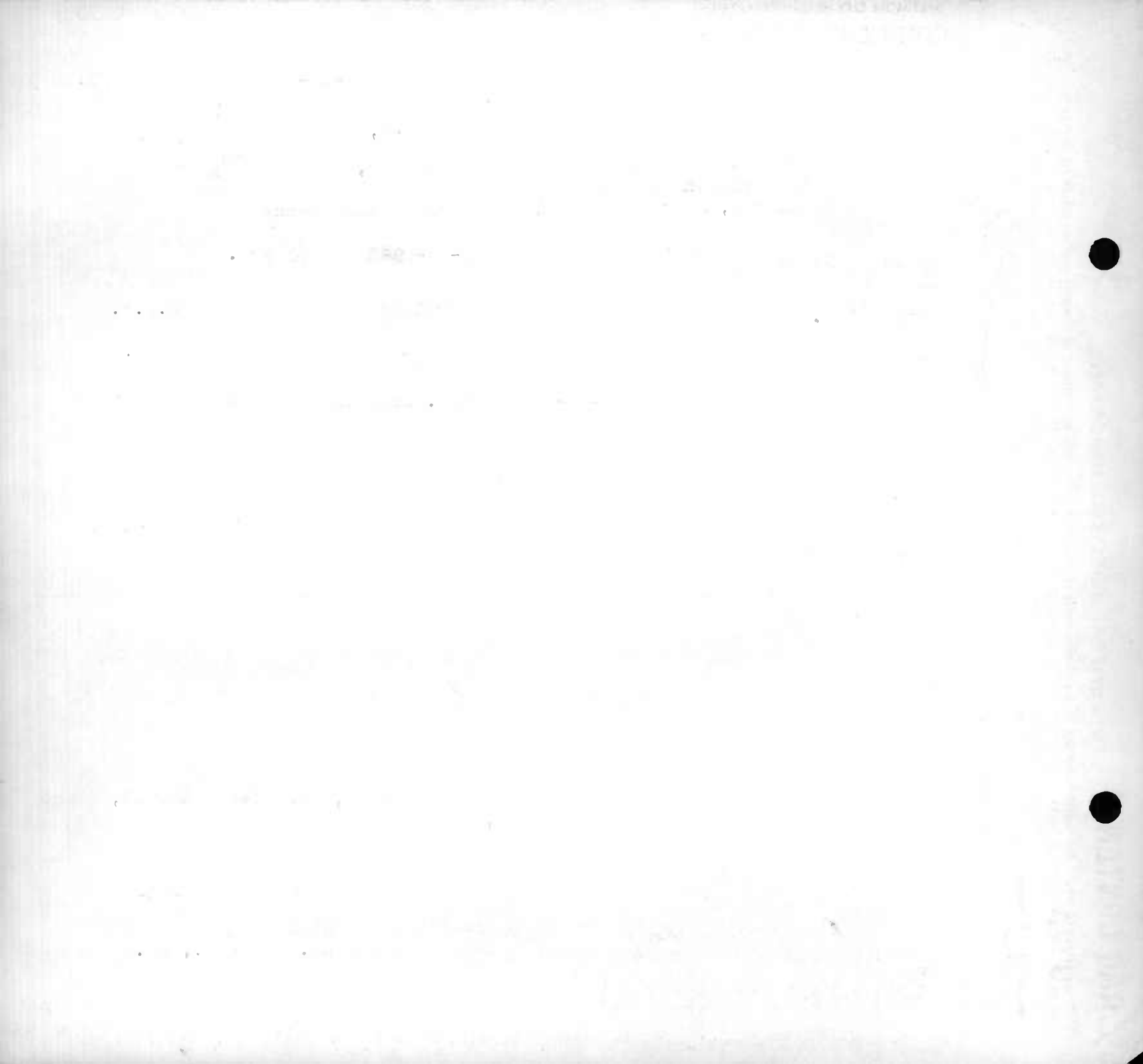
WARTON & SONS

WARTON & SONS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09531		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 09531	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Mary Johnson</b>			2. DATE AND HOUR OF DEATH <b>9-18-66</b> <b>1:10 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital</b> <b>1514 Division Street</b> <b>Baltimore, Maryland 21217</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland,</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore,</b> D. STREET ADDRESS (If rural, give location) <b>2222 Callow Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>2-25-1886</b>	9. AGE (In years last birthday) <b>80 yrs.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Jack Williams</b>			14. MOTHER'S MAIDEN NAME <b>Laura</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>215-01-5582</b>	17. INFORMANT ADDRESS <b>Mrs. Irma Dixon (Daughter) Same</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> <b>Coronary atherosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>September 16, 1966</b> to <b>September 18, 1966</b> , that (I) (we) last saw the deceased alive on <b>September 18, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9-20-66</b>
23C. PHYSICIAN'S NAME (Type) <b>RAMACHANDRAN</b>			23D. ADDRESS M.D. <b>Provident Hospital</b> <b>1415 Division St. Balto., Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9-25-66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mount Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mortimer Dyett F.H. 1701 Laurens St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <span style="font-size: 1.2em;">66 09532</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 1.2em;">66 09532</span>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Mr. FLOYD DAVIS</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">9-18-66</span>   <span style="font-size: 1.2em;">8<sup>20</sup> A.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">BALTIMORE</span> B. COUNTY <span style="font-size: 1.2em;">23</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">2623 Edmondson Ave.</span>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">Bon Secours Hospital</span>		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">2623 Edmondson Ave.</span>			
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">NEGRO</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARRIED</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">2/2/12</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">54</span>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Forklift</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Gen'l Electric Co.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">S. Carolina</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">FURMAN DAVIS</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MARY Young</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No.</span>		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Anna Davis</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <span style="font-size: 1.2em;">Massive GI. Hemorrhage</span> (B) DUE TO <span style="font-size: 1.2em;">Lipoma hemorrh. gastritis</span> (C) <span style="font-size: 1.2em;">Cirrhosis &amp; hepatoma</span> <span style="font-size: 1.2em;">Chronic alcoholism</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1 day</span>  <span style="font-size: 1.2em;">year</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/>   Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <span style="font-size: 1.2em;">9-1-66</span> to <span style="font-size: 1.2em;">9-18-66</span> , that <del>the</del> (we) last saw the deceased alive on <span style="font-size: 1.2em;">9-18-66</span> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>the</del> (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Y. Chung</span> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Y. CHUNG</span>		23D. ADDRESS <span style="font-size: 1.2em;">Bon Secours Hosp.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">9-22-66</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Carter Mem. Park</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Laurel Maryland</span>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Morton D. Dylott</span>		25D. ADDRESS			

SEP 21 1966

YES

P-12

12

P-11

P-11

X

Y - CHINESE

Y - CHINESE

Y - CHINESE

66 09533

BALTIMORE CITY HEALTH DEPARTMENT

66 09533

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ELSIE (Essie) CRAWFORD

2. DATE AND HOUR PRONOUNCED DEAD

September 16, 1966 11:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Franklin Square Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

634 N. Carrollton Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

4-11-1937

9. AGE (In years  
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Hartsville, S.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Robinson

14. MOTHER'S MAIDEN NAME

Julia

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

247-56-6933

17. INFORMANT

Mr. Hugh Crawford

ADDRESS

1825 Baker Street

18.

2982X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Stab wound of chest

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRI-  
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Front of 632 N. Carrollton Avenue

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

9 16 '66 P.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed during altercation.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/17/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9-24-66

23C. NAME of CEMETERY or CREMATORY

Kingsville Meth. Church Cem.

23D. LOCATION

(City, town, or county)

(State)

Hartsville, S.C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Morton E. Dyett F.H.

1701 Laurens St



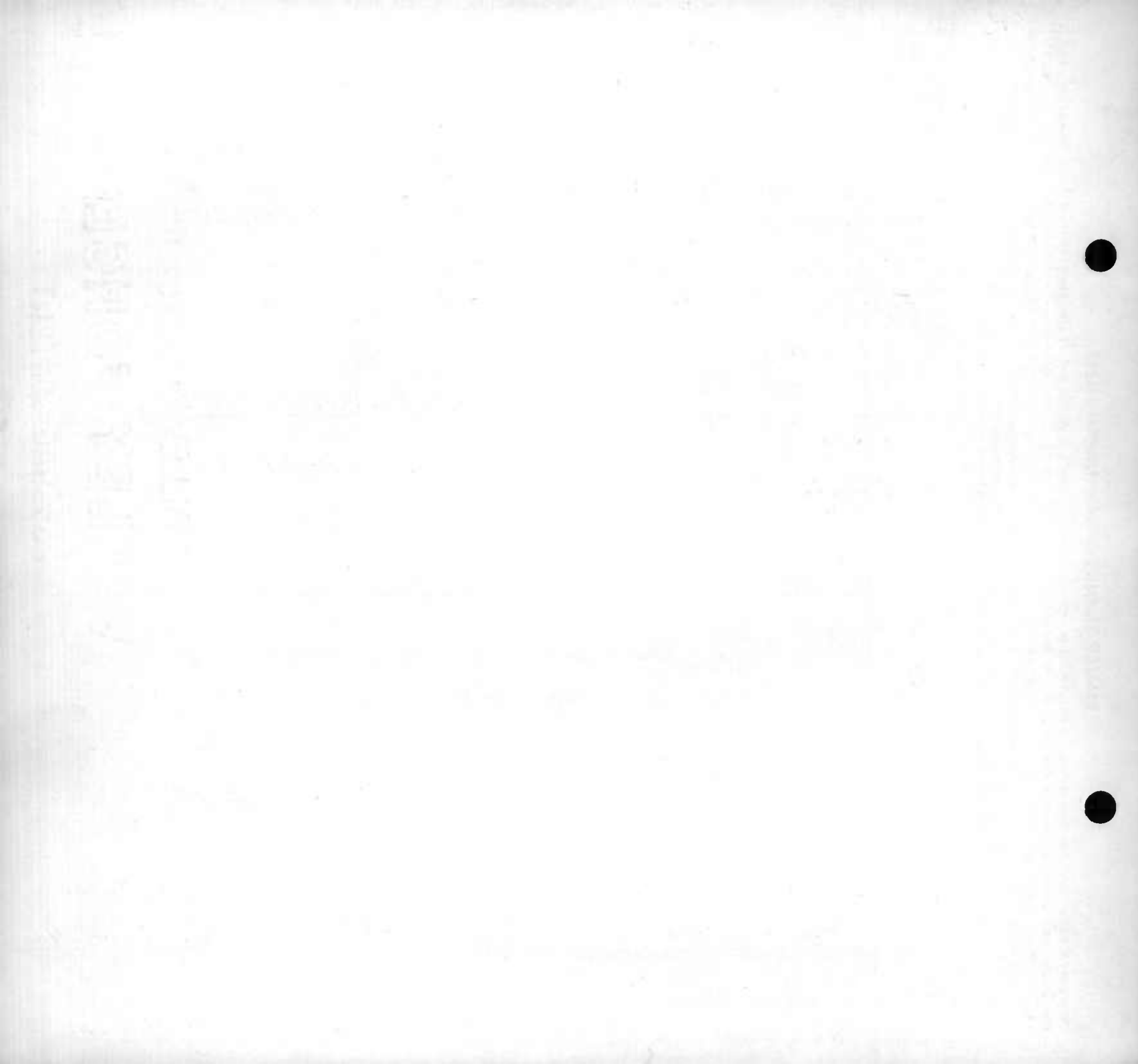




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

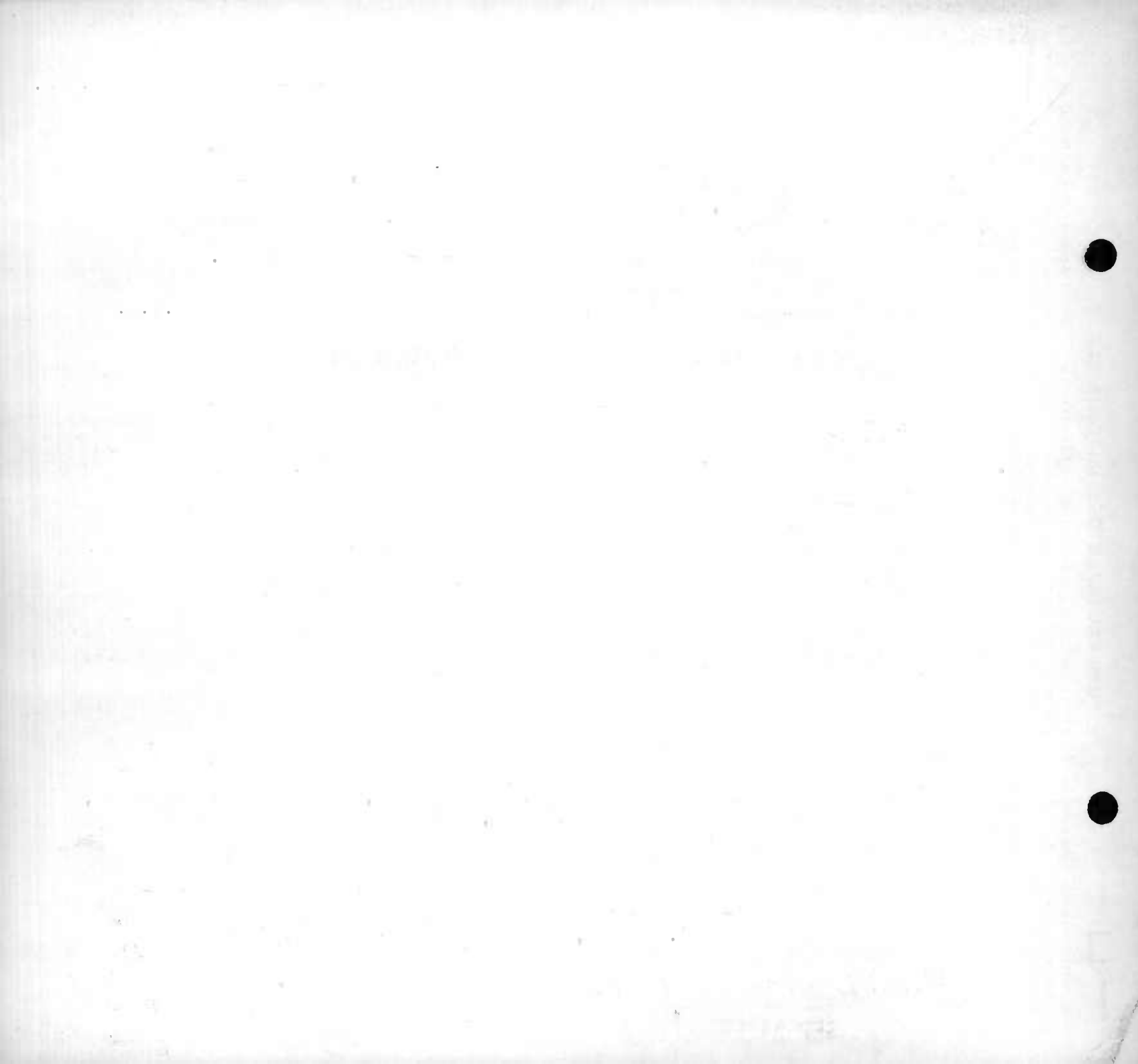
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09534	
BIRTH NO. 66 09534		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Frank Edward Glen</b>		2. DATE AND HOUR OF DEATH <b>9-19-66 12:40 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Lincoln Mem. N. Home</b>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO</b>	
		D. STREET ADDRESS (If rural, give location) <b>617 W. FRANKLIN ST</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Sep.</b>	8. DATE OF BIRTH <b>12-22-05</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PORTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bus Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Cedarville, GA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>UNK</b>		14. MOTHER'S MAIDEN NAME <b>UNK.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>IONA BAKER 2306 BRYANT AVE.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>127X I</b>		CAUSE OF DEATH (A) <b>Carcinoma of prostate Gland</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>Sept 13</b> 19 <b>66</b> to <b>Sept 19</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Sept 19</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Hollie Sennaline, M.D.</b>		23B. DATE SIGNED <b>9/20/66</b>		23C. PHYSICIAN'S NAME (Type) <b>HOLLIE SENNALINE</b>	
23D. ADDRESS <b>903 White lock ST. BALTO, Md.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-20-66</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT. CALVARY</b>		24D. LOCATION (City, town, or county) (State) <b>A.A. Co Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1966</b>	
25B. NAME OF REGISTRAR <b>ALAN E. Isadore</b>		25C. FUNERAL DIRECTOR <b>MORTON DYEIT</b>		25D. ADDRESS <b>1701 LAURENS ST.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09535</b>	
BIRTH NO. <b>66 09535</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>9-19-66 1:55p. M.</b>	
1. NAME OF DECEASED (Type or Print) <b>George Young</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital 1514 Division Street Baltimore, Maryland 21217</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore, 15-02</b> D. STREET ADDRESS (If rural, give location) <b>1342 N. Fulton Avenue</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>5-15-10</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sparrows Point-Burner</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>	9. AGE (In years last birthday) <b>55 yrs.</b>
13. FATHER'S NAME <b>John Young</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO. <b>219-09-5819</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET Higgins</b>	
17. INFORMANT <b>Gertrude Young (Wife)</b>		ADDRESS <b>Same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>334 XI</b>		CAUSE OF DEATH (A) DUE TO <b>Emphysema, right temporal lobe</b> (B) DUE TO <b>severe atherosclerosis</b> (C) <b>coronary arteries</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>September 6, 19 66</b> to <b>September 19, 19 66</b> , that (I) (we) lost saw the deceased alive on <b>September 19, 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>9-20-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>C. Laredo, M.D.</b>		23D. ADDRESS <b>Provident Hospital 1514 Division Street Balto., Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>9-21-66</b>	24C. NAME OF CEMETERY or CREMATORY <b>ARBUTUS</b>	24D. LOCATION (City, town, or county) (State) <b>BALTO. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1966</b>	25B. NAME OF REGISTRAR <b>R. E. Farber</b>	25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; Dyer H. 1701 LAURENS</b>	



R-163

66 09536

BALTIMORE CITY HEALTH DEPARTMENT

66 09536

BIRTH NO. <u>66-15020</u>		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>Charlotte T. Roberts</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>9/19/66 1:00 p.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2132 N. Calvert St.</b>	
5. SEX <b>female</b>	6. RACE <b>colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never Married</b>	8. DATE OF BIRTH <b>7-24-66</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10B. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
13. FATHER'S NAME <b>Leon Roberts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>Teremezia Greene</b>	16. SOCIAL SECURITY NO. <b>None</b>
17. INFORMANT <b>Leon Roberts - 2132 N. Calvert St.</b>		ADDRESS	
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Interstitial pneumonitis and dehydration (SDII)</b> DUE TO II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) _____ (B) _____ (C) _____ III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____ 19A. DATE OF OPERATION <b>9-23-66</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>yes</b> 20A. AUTOPSY? (Yes or No) <b>yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b> 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>yes</b> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>yes</b> 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>yes</b> 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? <b>yes</b> 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9/20/66</b>			
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23B. DATE <b>9-22-66</b>	23C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>	23D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
24A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1966</b>	24B. NAME OF REGISTRAR <b>Charles R. Law</b>	24C. FUNERAL DIRECTOR ADDRESS <b>802 Madison Ave.</b>	

WALTON

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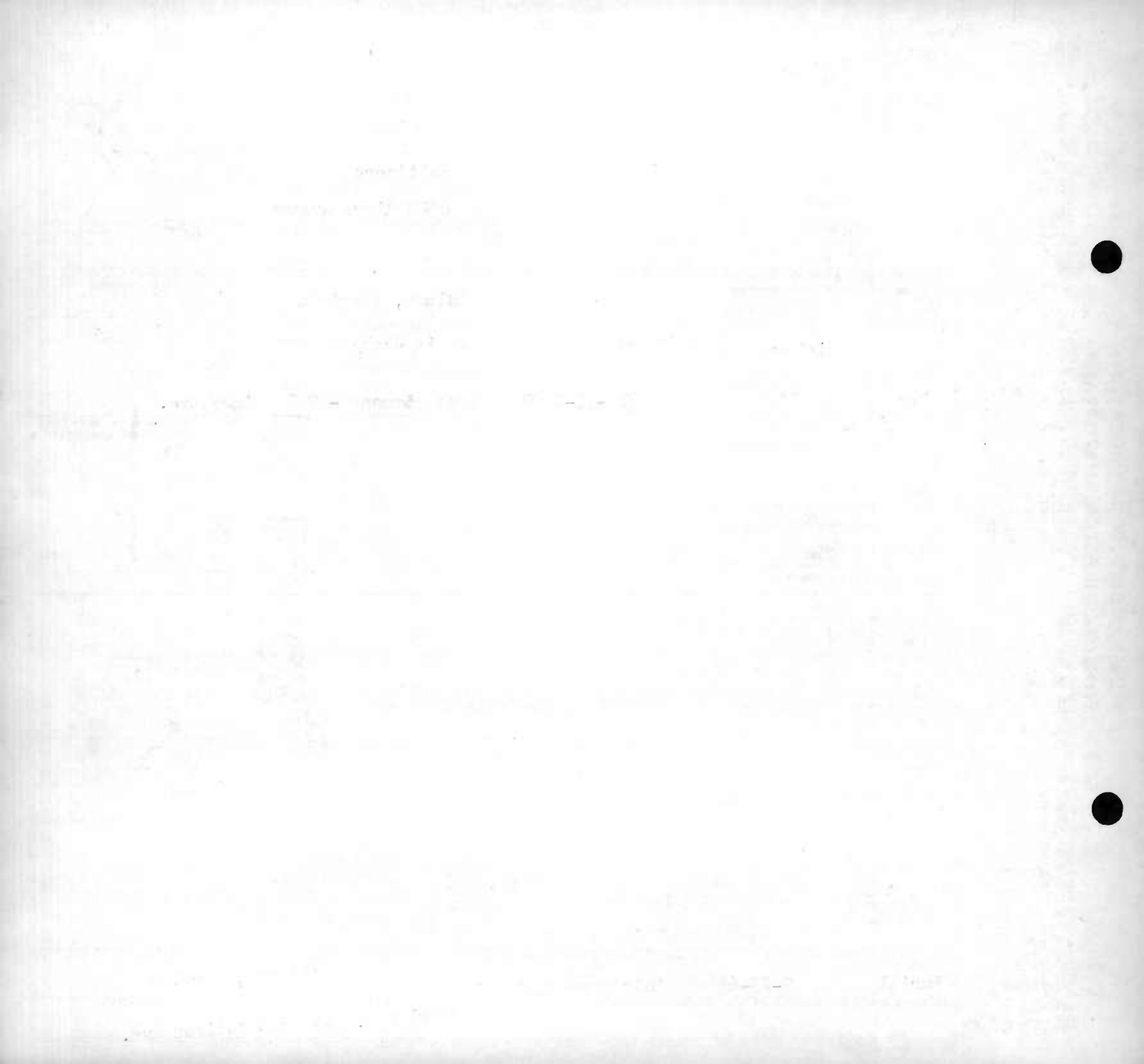
1921

1922

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09537				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09537	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CLARENCE ROSCOE WASHINGTON				2. DATE AND HOUR OF DEATH 9.20-66 11:00/AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV. HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 16-07			
				D. STREET ADDRESS (If rural, give location) 2928 Riggs Avenue			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 6.20.14	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USA Post office			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Saluda, Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Richard Washington				14. MOTHER'S MAIDEN NAME Essie Jackson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 218-07-1459		17. INFORMANT ADDRESS Leah Simmons - 2928 Riggs Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 163X I CARCINOMA OF LUNG				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (we) (this hospital) attended the deceased from 9.16.66 to 9.20.66 that (we) lost saw the deceased alive on 9.19.66 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stuart L. Fine				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9.20.66	
23C. PHYSICIAN'S NAME (Type) STUART L. FINE M.D.				23D. ADDRESS UNIV HOSP BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-23-66		24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Charles R. Law		25C. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Ave.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

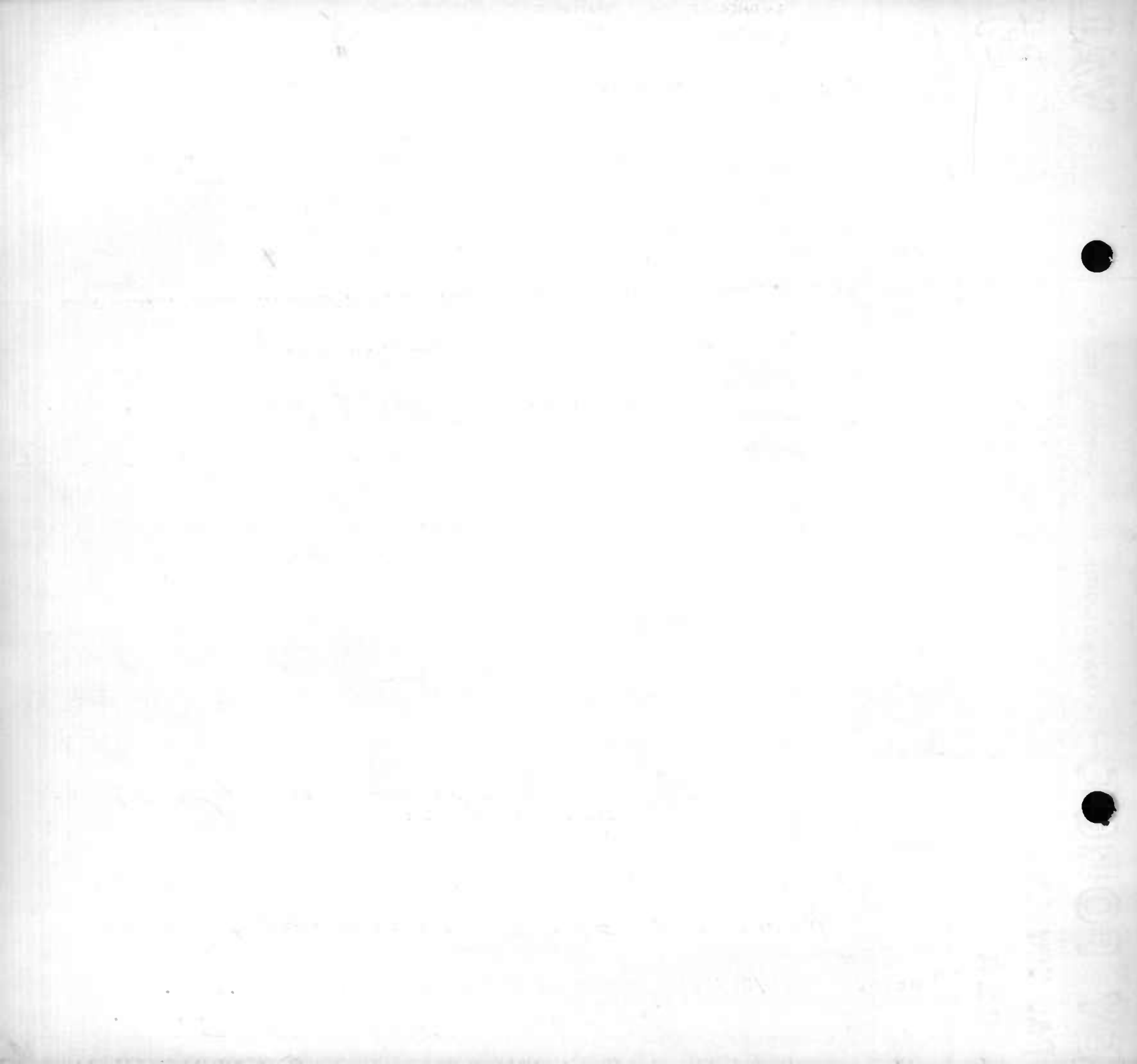
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09538</b>	
BIRTH NO. <b>66 09538</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>JOSEPH BISHOP</b>		2. DATE AND HOUR OF DEATH <b>9/19/66</b>   <b>12:33</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME &amp; HOSPITAL</b>		A. STATE <b>Md.</b> B. COUNTY <b>26-44</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #24</b>			
		D. STREET ADDRESS (If rural, give location) <b>3613 Polaris Hwy.</b>			
5. SEX <b>M</b>	6. RACE <b>CAU.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>2/13/84</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own Business</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Faustien Bishop</b>		14. MOTHER'S MAIDEN NAME <b>Anna Wasewitz</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-48-6715</b>		17. INFORMANT <b>Lucie Altmann, dght. above</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>DIABETES MELLITUS</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2-3yr.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>PNEUMONIA, RENAL DISORDER SUSPECT CEREAL ARTERIO SCLEROSIS</b>			
19A. DATE OF OPERATION <b>1/8/30/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GALLBLADDER @ LGS</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>8/19</b> 19 <b>66</b> to <b>9/19</b> 19 <b>66</b> , that (I) <del>lost</del> lost saw the deceased alive on <b>9/19</b> 19 <b>66</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did) <del>not</del> view the body after death.					
23A. SIGNATURE <b>Merwin L. Thar</b>		M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/19/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MERWIN L. THAR</b>		23D. ADDRESS <b>Church Home &amp; Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/23/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Starkey</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>			
25D. ADDRESS <b>3331 Brehms Lane #13</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 09539</span>	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <span style="font-size: 1.5em;">66 09539</span></p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Albert J. Willem</span></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">9:20 AM 9/17/66</span> M.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">South Baltimore General Hospital</span></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore 26-03</span></p> <p>D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">3810 Elmora Ave. Elmore</span></p>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">7/12/02</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">64</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Clerk</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Edward Willem</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Augusta Daus</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213 10 1042</span>		17. INFORMANT <span style="font-size: 1.2em;">self</span> Address Above Augusta Willem, wife,	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Paranasal cancer with metastasis to liver</span>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <span style="font-size: 1.2em;">Generalized arteriosclerosis</span>		
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">6 months</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Sept. 6 1966</span> to <span style="font-size: 1.2em;">Sept. 17 1966</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Sept. 17 1966</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Romulo V. Goco</span> M.D.				23B. DATE SIGNED <span style="font-size: 1.2em;">8/18/66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Romulo V. Goco</span> M.D.				23D. ADDRESS <span style="font-size: 1.2em;">5500 Bowleys Lane</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">9/21/66</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Gardens of Faith Cemetery</span>	
				24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Balto., Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">SEP 21 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Schimunek Funeral Home, Inc.</span> <span style="font-size: 1.2em;">3331 Brehms Lane #13</span>	



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN

HINKLE

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1966

4:59 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3504 Clifftmont Avenue #13

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4/22/17

9. AGE (In years  
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Draftsman

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Hinkel

14. MOTHER'S MAIDEN NAME

Anna Dunkes

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. (If yes, give war or dates of service))

no

16. SOCIAL  
SECURITY NO.

218-03-5105

17. INFORMANT

Audrey Hinkel, wife, above

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/18/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9/22/66

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cemetery

23D. LOCATION

(City, town, or county)

Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

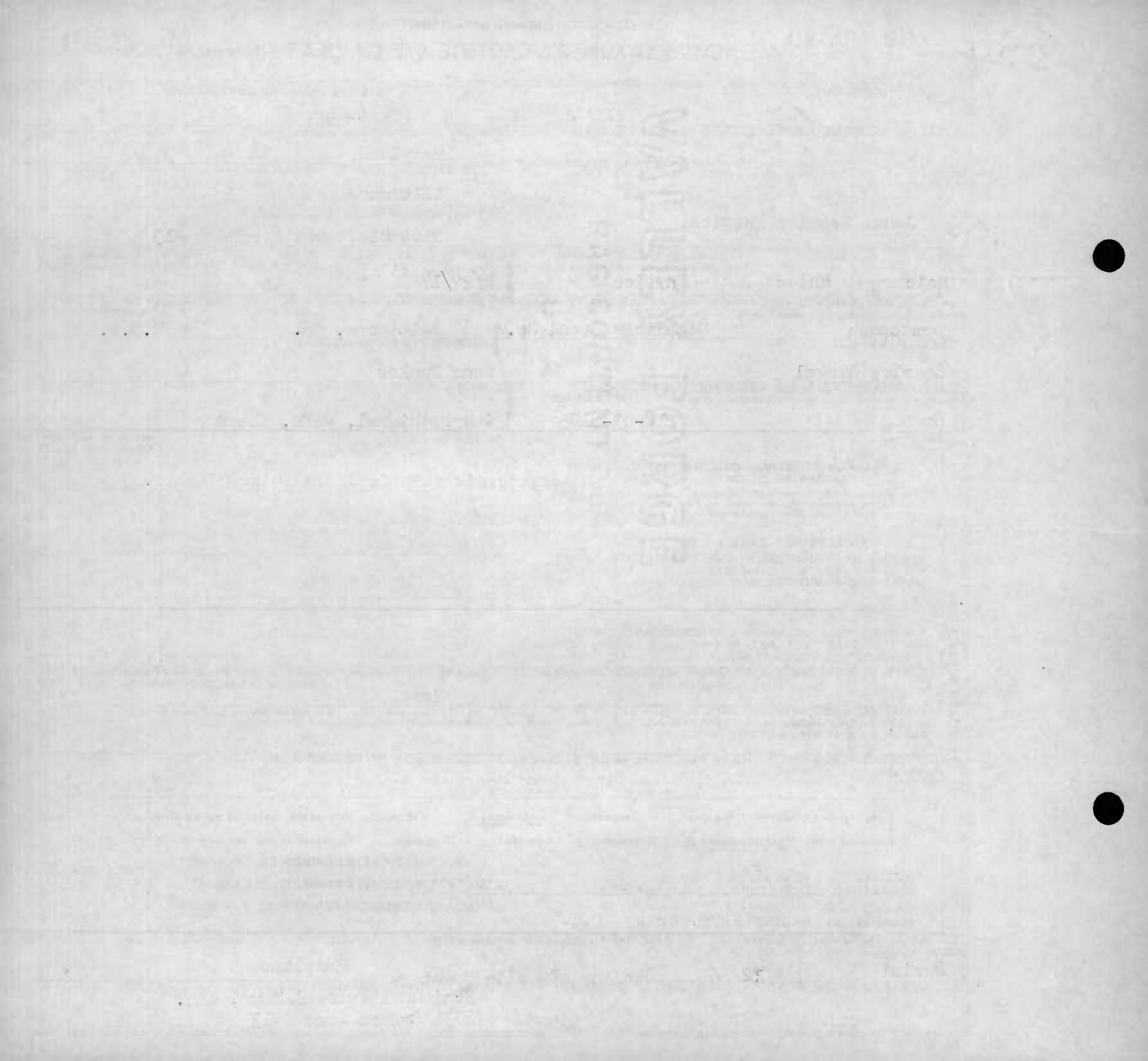
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Schimmek Funeral Home, Inc.

ADDRESS

3331 Brehms Lane #13



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09541		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09541	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		CURRID, MARGARET MARY		2. DATE AND HOUR OF DEATH SEPTEMBER 16, 1966 1:55P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-41			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MD. 21229		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 311 OAKLEE VILLAGE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 9-30-89	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES J. CURRID		14. MOTHER'S MAIDEN NAME BARBARA STRAHLER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 214032702		17. INFORMANT MISS ELIZABETH CURRID, 311 OAKLEE ST. AGNES HOSPITAL RECORDS VILLAGE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Confluent Bronchopneumonia 3 weeks (B) Congestive Heart failure - secondary (C) Atherosclerosis, aortic, coronary arteries - mult - unknown		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 26 19 66 to SEPTEMBER 16 19 66, that (I) (we) last saw the deceased alive on SEPTEMBER 16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ogh		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/16/66	
23C. PHYSICIAN'S NAME (Type) Philip W. Lelan M.D.		23D. ADDRESS ST. AGNES HOSP; CATON & WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-20-66		24C. NAME of CEMETERY or CREMATORY NEW CATHEDRAL CEMETERY	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. SEP 21 1966			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229			

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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09542</u>	
BIRTH NO. <u>66 09542</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>KALER, JOHN LEROY</b>		2. DATE AND HOUR OF DEATH <b>9-19-66 3:05AM M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <u>20-05</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL BALTIMORE, 29, MD</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>2605 WILKENS AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9-1-99</b>	9. AGE (In years lost birthday) <b>67</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AUTO MECHANIC</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GARAGE</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>JOHN KALER (DEC'D)</b>			
14. MOTHER'S MAIDEN NAME <b>ANNIE ESSLINGER (DEC'D)</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>217 05 8885</b>		17. INFORMANT <b>MRS. OLIVE R. KALER, SAME AS 4d</b> <b>ST. AGNES HOSPITAL RECORDS</b>			
18. <u>4-20-1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <u>Acute Congestive Heart Failure</u> DUE TO (B) <u>Diffuse Myocardial Disease</u> DUE TO (C) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>9-16</u> 19 <u>66</u> to <u>9-19</u> 19 <u>66</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>9-19</u> 19 <u>66</u> and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Romualdo R. Dator</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Sept. 19, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Romualdo R. Dator</u>		23D. ADDRESS <u>St. Agnes Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-22-66</b>		24C. NAME of CEMETERY or CREMATORY <b>LOUDON PARK CEMETERY</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1966</b>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <b>HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229</b>			

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M-620 66 09543

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 09543

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)A.  
Arthur Morris

2. DATE AND HOUR PRONOUNCED DEAD

9/19/66 2:10 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

New York

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

New York

D. STREET ADDRESS (If rural, give location)

170 W. 74th St. APT. 704

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)  
MARRIED

8. DATE OF BIRTH

2-11-1886

9. AGE (In years  
last birthday)

80 81

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

SALES

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

OHIO

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

WILSON MORRIS

14. MOTHER'S MAIDEN NAME

CLEMENTINE PARKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.  
-----

17. INFORMANT

ADDRESS

MRS. CHRISTINE MORRIS, 170 W. 74th ST. NEW YORK

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Massive pulmonary embolism, complicating  
- DUE TO fracture of left hip

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2 7/28/66

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

fracture left hip

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

hospital

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Hopkins Hospital

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
7 28 66 ?

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

fell on floor

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/19/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

9-22-66

23C. NAME OF CEMETERY or CREMATORY

LOUDONVILLE CEMETERY

23D. LOCATION

(City, town, or county)

(State)

LOUDONVILLE,

OHIO

24A. DATE REC'D BY HEALTH DEPT.

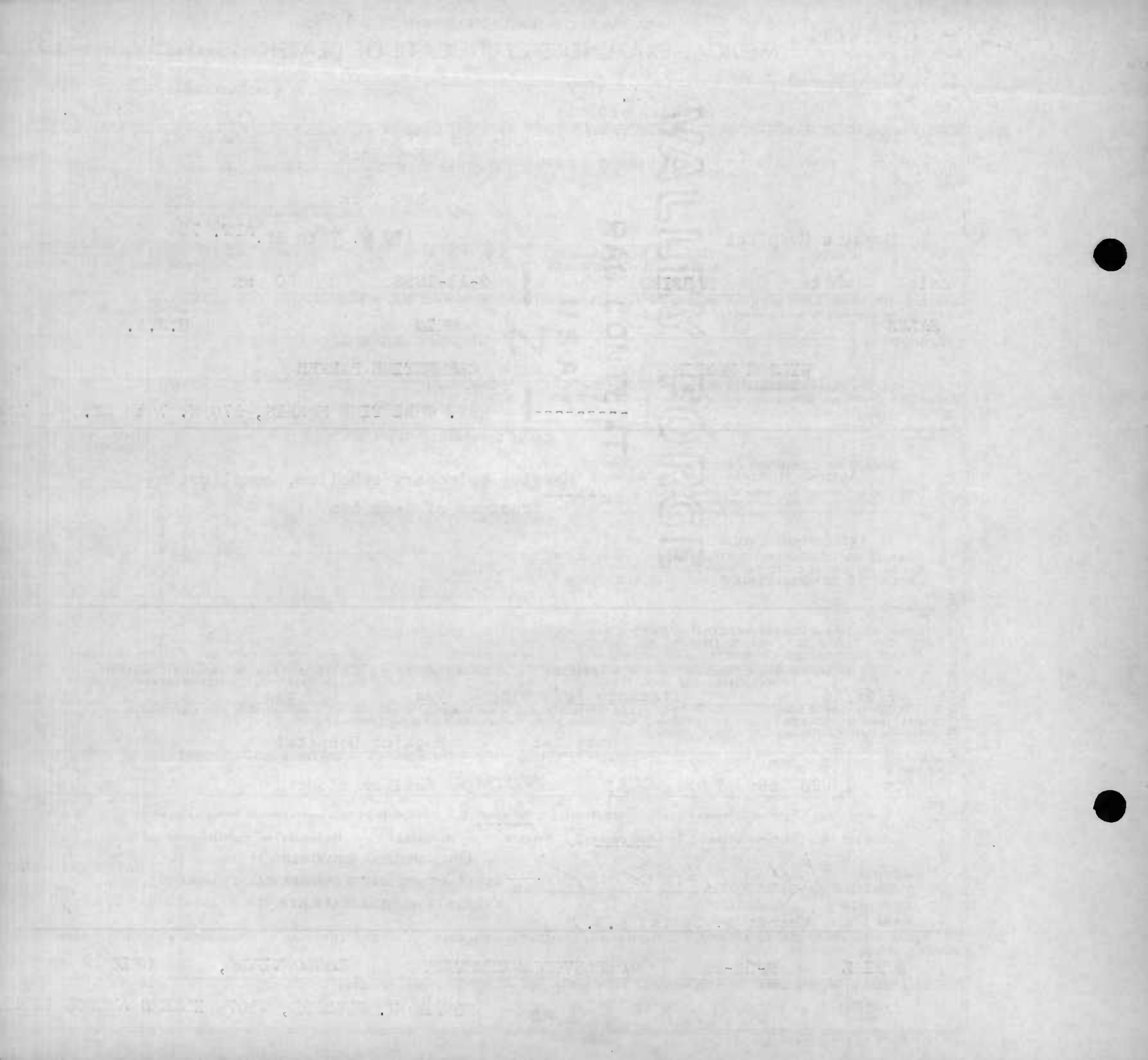
SEP 21 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

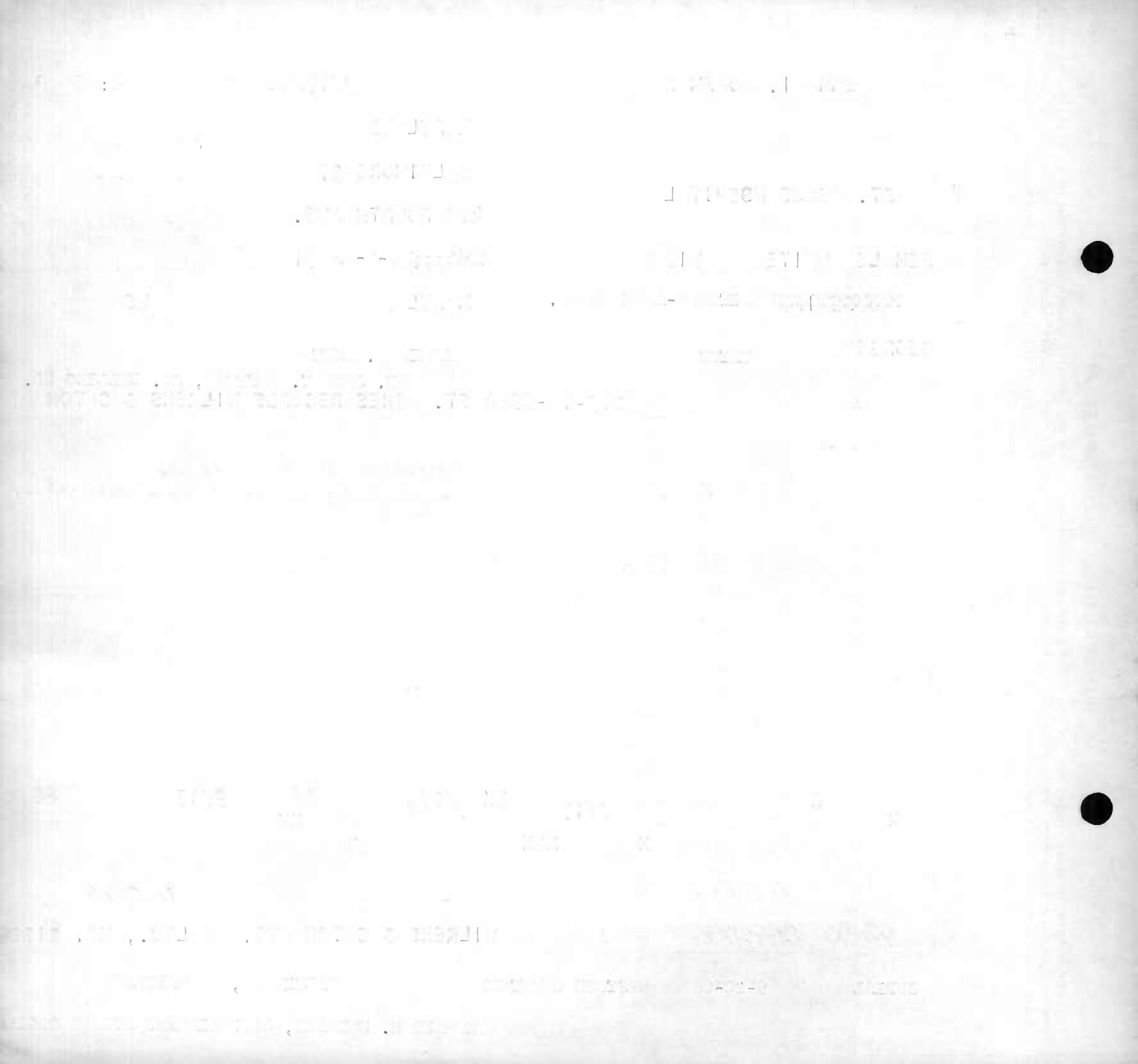
HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>X 66 09544</b>	
BIRTH NO. <b>66 09544</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>EMMA I. HOFFMAN</b>		2. DATE AND HOUR OF DEATH <b>9/17/66 4:00 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 27</b> D. STREET ADDRESS (If rural, give location) <b>410 FOURTH AVE.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>8-2-95 9-2-95 71</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>WAITRESS-ARUNDEL CO.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>GEORGE YATES</b>			14. MOTHER'S MAIDEN NAME <b>ANNIE E. BENTON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-10-7594</b>		17. INFORMANT <b>MR. JOHN T. HOFFMAN, SO. ROLLING RD. ST. AGNES RECORDS WILKENS &amp; CATON</b>	
18. <b>330X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Subarachnoid hemorrhage Rupture aneurysm ant. communicating artery</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION <b>9-16-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ruptured Aneurysm</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/29/66</b> to <b>9/17/66</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>9/17/66</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <i>M. N. Hattarki</i>				23B. DATE SIGNED <b>9/17/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. N. HATTARKI</b>		23D. ADDRESS M.D. <b>WILKENS &amp; CATON AVE. BALTO., MD. 21229</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>9-20-66</b>	24C. NAME OF CEMETERY or CREMATORY <b>WESTERN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1966</b>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <b>HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229</b>	



BIRTH NO. 86 0954 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66-09545

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)	William O'Connor	2. DATE AND HOUR PRONOUNCED DEAD	9/18/66 11:00 p. M.
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3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	A. STATE
	B. COUNTY
	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Union Memorial Hospital	Maryland
	Baltimore
	D. STREET ADDRESS (If rural, give location)

	4513 Wilmslow Rd.
--	-------------------

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
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male	white	Widowed	June 12, 1891	75		
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10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
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Operator	Machine Shop	Ireland	USA
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13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
-------------------	--------------------------

William J. O'Connor	Mary O'Brien
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
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Yes	WWI	218-07-1385	Treva E. Bortner 4527 Keswick Road
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18. CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
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DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	Arteriosclerotic cardiovascular disease
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(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO
--	------------

ANTECEDENT CAUSES	(B) DUE TO
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DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C) DUE TO
---	------------

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
--	--

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
------------------------	--	---------------------------	--

		NO	
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21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
--	---	--

21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
-------------------------------	----------------------	----------------------------

	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
--	---	--

22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
---

ACTUAL SIGNATURE	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
------------------	---	-------------

EXAMINER'S NAME (Type)	M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
------------------------	---	--

Werner U. Spitz, M.D.	ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	9/19/66
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23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
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Burial	22 Sept 66	Greenmount Cemetery	Baltimore, Maryland
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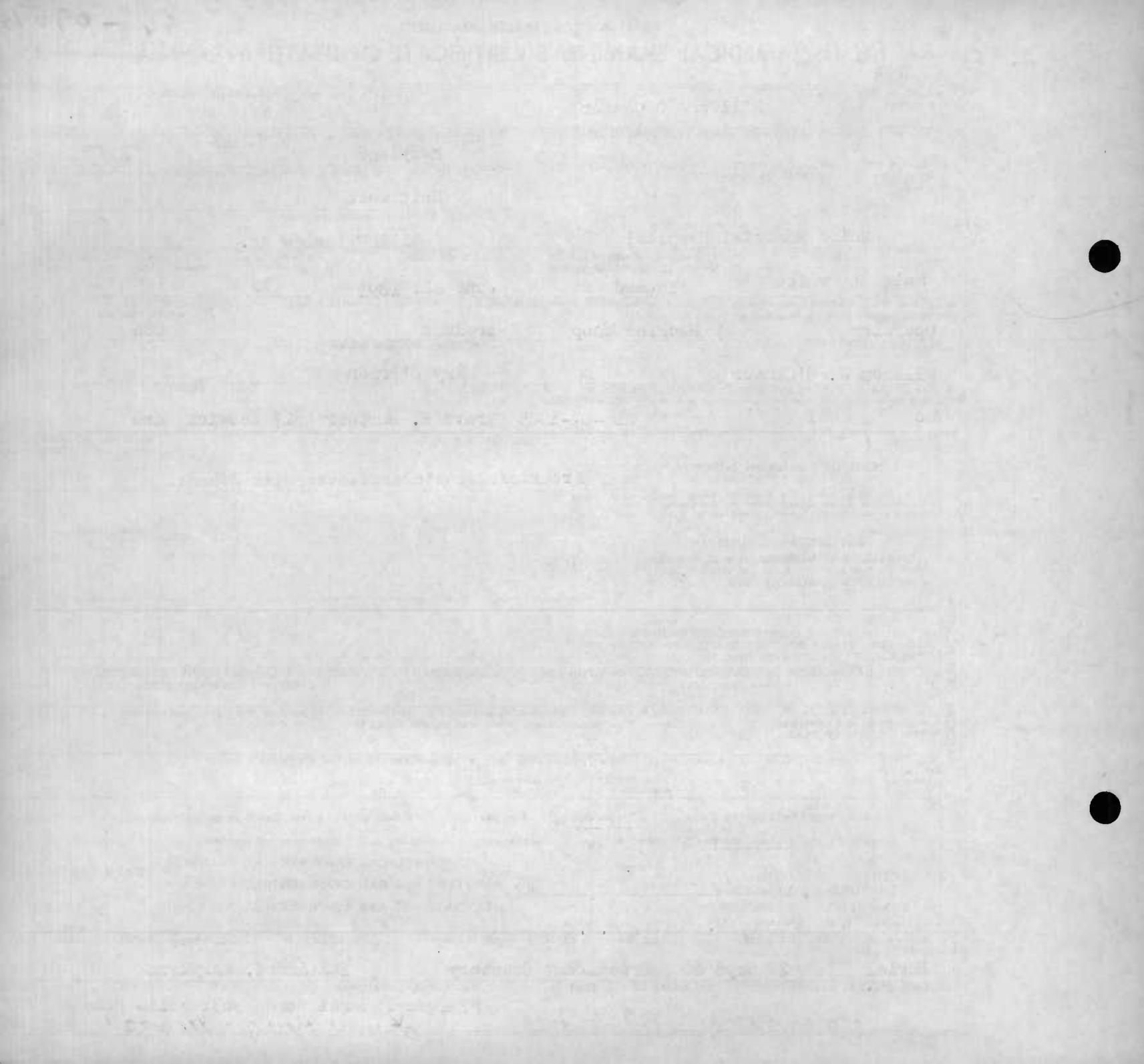
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
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		Burgee Funeral Home	3631 Falls Road
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SEP 22 1966		Lynn Burgee Henss	
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VS 151-REV. 1/1/65			
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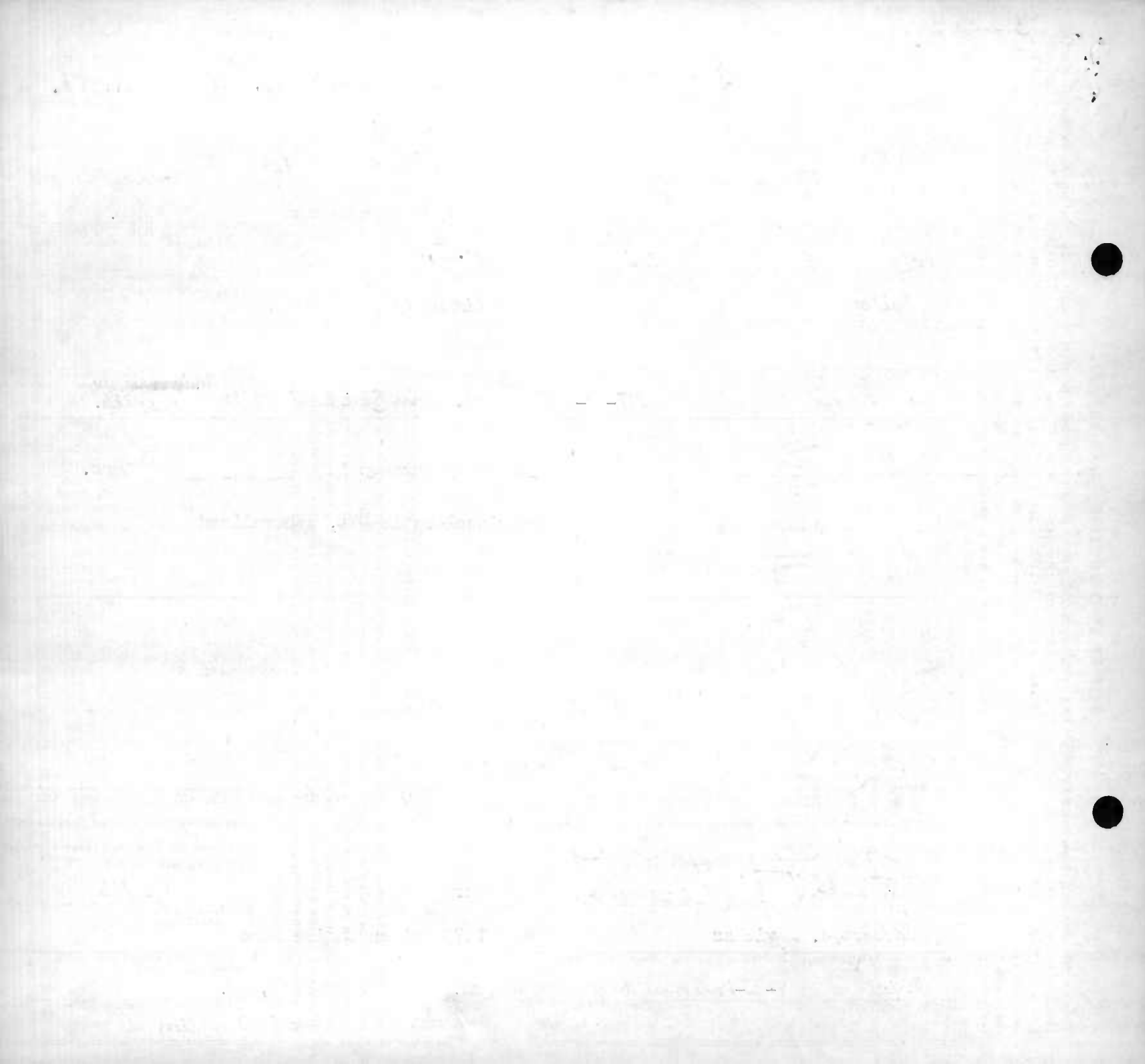




# FUNERAL DIRECTOR: IMPORTANT

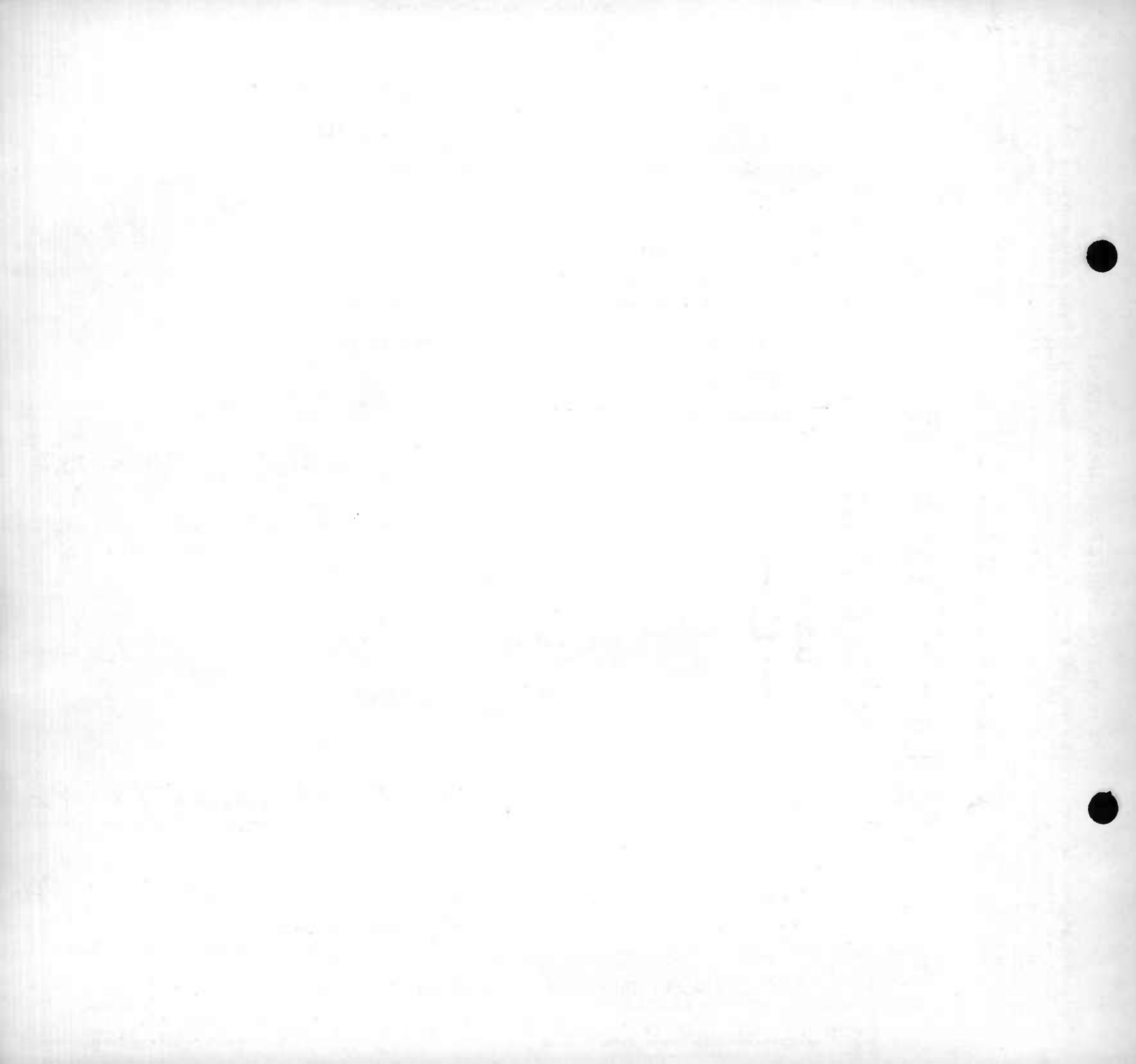
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>86 09546</u>	
BIRTH NO. <u>66 09546</u>										CERTIFICATE OF DEATH	
M.E. CASE NO. <u>66 09546</u>										1. NAME OF DECEASED (Type or Print) <u>Joseph J. Balchunas</u>	
2. DATE AND HOUR OF DEATH <u>September 19, 1966</u> <u>11:30 A.</u> M.											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>1708 De Soto Road</u>										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>21230</u> <u>25-52</u>	
D. STREET ADDRESS (If rural, give location) <u>1708 De Soto Road</u>											
5. SEX <u>Male</u>	6. RACE <u>wh</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 27, 1883</u>	9. AGE (in years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>										12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> <u>no</u>										16. SOCIAL SECURITY NO. <u>217-52-5387</u>	
17. INFORMANT <u>Mrs. Agnes Craighead</u>										ADDRESS <u>5003 Adenbrook Ave Lakewood, Calif.</u>	
18. <u>420.1 I</u> CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Coronary thrombosis</u>										<u>4 hrs.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic CVD, generalized</u>											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (netely medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (APPROX.)										21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?											
22. I certify that (I) (this hospital) attended the deceased from <u>3/30</u> <u>1966</u> to <u>9/19</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>9/19</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Herbert J. Levickas</u> M.D.										23B. DATE SIGNED <u>9/20/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u>										23D. ADDRESS <u>1073 Maiden Choice Lane</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>										24B. DATE <u>9-22-1966</u>	
24C. NAME of CEMETERY or CREMATORY <u>Most Holy Redeemer Cem.</u>										24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1966</u>										25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>Thomas J. Kenny Inc</u>										ADDRESS <u>1600 Hollins St</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09547				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09547	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Andrew C. Simms</b>				2. DATE AND HOUR OF DEATH <b>September 18, 1966</b>   <b>9:00 a</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Gould Convalesarium</b> <b>6116 Belair Road</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland, 21211</b> B. COUNTY <b>12-07</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>206 West Lorraine Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>Married</b>	8. DATE OF BIRTH <b>July 23, 1886</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Eden, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Rufus Simms</b>			14. MOTHER'S MAIDEN NAME <b>Charlotte Whyland</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-12-1278</b>		17. INFORMANT <b>Esty M. Simms (Wife)</b>			
18. <b>430101</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary embolism sudden acute</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Generalized severe arteriosclerosis</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Emaciation</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Sept. 15, 1966</b> to <b>Sept 18, 1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Sept 16, 1966</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Harold V. Harbold</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>Sept. 20, 1966</b>			
23C. PHYSICIAN'S NAME (Type) <b>Harold V. Harbold</b>		23D. ADDRESS <b>4706 Harford Road - 14 Baltimore Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/21/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Johns Methodist Church Cemetery Fruitland, Md.</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>R. E. Farley</b>		25C. FUNERAL DIRECTOR <b>Eugenia K. Seitz</b> ADDRESS <b>5209 York Rd. Balto. Md. 21212</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">66 09548</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 1.5em;">66 09548</span>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">FRANCO, ANGELINA D.</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">9-16-66</span> <span style="font-size: 1.2em;">1:00A</span> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">ST. AGNES HOSPITAL</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">PIKEVILLE</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">1 CHURCH LANE</span>		
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARRIED</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">66</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">66</span>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Pharmacist</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">own Business</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">FLORIDA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">LUIS DALMAU</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">ISOLINA GUTEIRRAE</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">None</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">None</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">ST. AGNES RECORDS -CATON &amp; WILKENS AVE</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">420.1 I</span> <span style="font-size: 1.2em;">Cardiogenic Shock</span>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <span style="font-size: 1.2em;">Myocardial Infarction, Acute</span> (C) <span style="font-size: 1.2em;">A.S.C.V.D.</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">no</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">AUGUST 15</span> 19 <span style="font-size: 1.2em;">66</span> to <span style="font-size: 1.2em;">SEPTEMBER 16</span> 19 <span style="font-size: 1.2em;">66</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">SEPTEMBER 16</span> 19 <span style="font-size: 1.2em;">66</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">E. Weiss</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">9/16/66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">E. WEISS</span>		23D. ADDRESS <span style="font-size: 1.2em;">ST. AGNES HOSPITAL; CATON &amp; WILKENS AV.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">SEP 22 1966</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Pikeville Ridge Cemetery</span>	
24D. LOCATION (City, town or county) <span style="font-size: 1.2em;">Pikeville 8, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">SEP 22 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farley, M.D.</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Philip Servato</span>		25D. ADDRESS <span style="font-size: 1.2em;">Pikeville 8, Md.</span>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09549				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09549	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>LUCILLE BARRICK</b>				2. DATE AND HOUR OF DEATH <b>SEPT. 14 1966 1:00 P.</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Mount Convalescent Home 3706 Norton Rd. Baltimore, Md.</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MD.</b>		B. COUNTY <b>20-03</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore, Md.</b>			
				D. STREET ADDRESS (If rural, give location) <b>1931 Christen St. Christian</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>May 22, 1886</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-16-0026A</b>		17. INFORMANT <b>Mt. Nursing Home, Baltimore, Md.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>156.1 I</b>				CAUSE OF DEATH (A) <b>Carcinoma of liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>July 13, 1966</b> to <b>Sept. 14, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept. 7, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Abraham B. Hurwitz</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Sept. 14, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>ABRAHAM B. HURWITZ, MD</b>				23D. ADDRESS <b>7501 Liberty Rd., Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>Sept. 16, 1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Windsor Ridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville 8, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Newell Funeral Home</b>		ADDRESS <b>1100 Reist Rd. Pikesville - Md.</b>	

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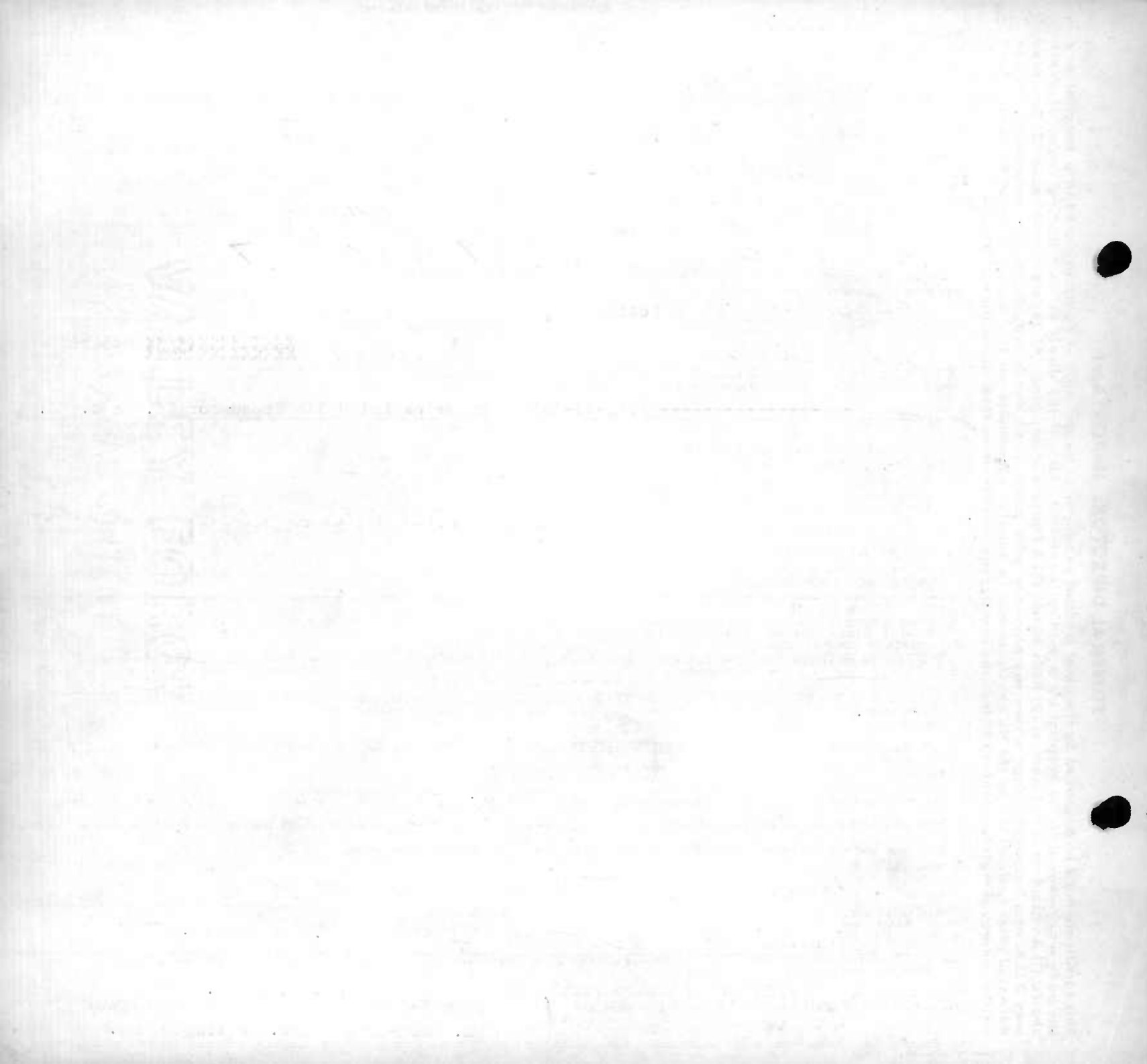
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 09550</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09550</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>JOSEPH DORN</b>		2. DATE AND HOUR OF DEATH <b>9/20/66 1:30 PM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>38 UNIVERSITY HOSPITAL BALT., MD 21201</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALT.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>21-01 BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>724 RAMSAY ST.</b>			
5. SEX <b>M</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>9/27/88</b>	9. AGE (In years lost birthday) <b>77</b>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN DORN</b>			
14. MOTHER'S MAIDEN NAME <b>MARY</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>212-03-3592</b>		17. INFORMANT ADDRESS <b>Mrs Selma Laird 316 Broadmoor Rd. Balt. Md. (12</b>			
18. <b>340.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>peritonitis</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>9/15/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>perforated pyloric ulcer</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/15/66</b> to <b>9/20/66</b> , that (I) (we) last saw the deceased alive on <b>9/20/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Carol E. West</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/20/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>CAROLE E. WEST</b>		23D. ADDRESS <b>University Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/23/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Inc. Baltimore, Md.</b>	



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66 09551

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09551

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

STEVE

REMBISZ

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1966

3:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

1-03

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

724 S. Milton Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

4-11-1904

9. AGE (In years  
lost birthday)

62

If Under 1 Yr. If Under 24 Hrs.  
Months; Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PRESS OPERATOR

10B. KIND OF BUSINESS OR INDUSTRY

CONTINENTAL CAN CO.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

GEORGE REMBISZ

14. MOTHER'S MAIDEN NAME

TILLIE ZAWOL

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

215-05-7344

17. INFORMANT

MR. MICHAEL REMBISZ

ADDRESS

724 S. MILTON AVE

18.

466 X 1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Pulmonary Artery Embolism  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Left Popliteal Vein Thrombosis.  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/18/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9-21-1966

23C. NAME of CEMETERY or CREMATORY

Holy Rosary Cemetery

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE Co. MD.

24A. DATE REC'D BY HEALTH DEPT.

SEP 22 1966

24B. NAME OF REGISTRAR

R. L. E. F. F. F.

24C. FUNERAL DIRECTOR

RAYMOND L. KACZOROWSKI

ADDRESS

2525 FLEET ST.

VALID FOR ONE YEAR

Since

8-11-1944

2

George Rembert

Frank Taylor

W. 7. 2

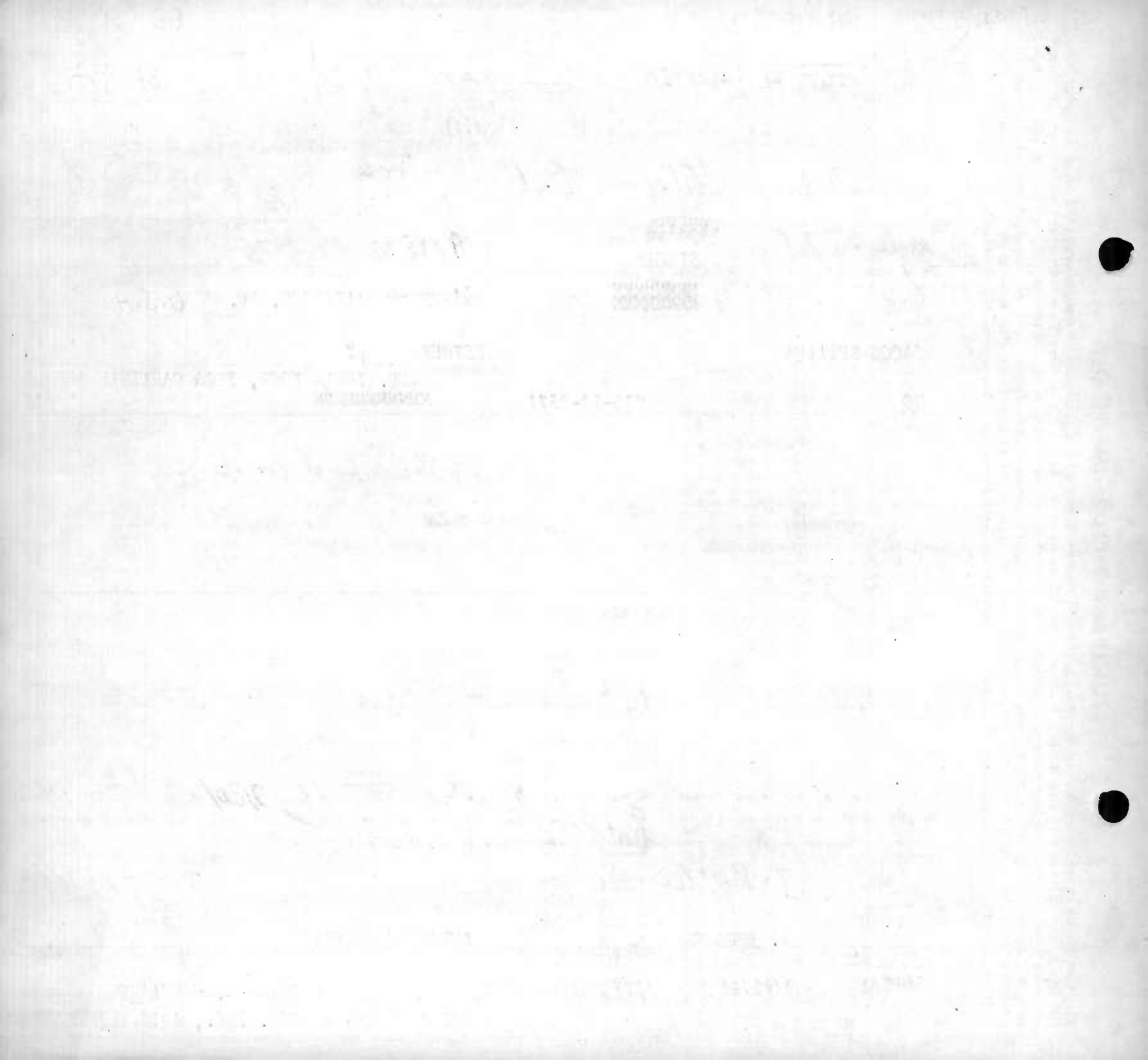
George Rembert 7-4 2 111

George Rembert  
Frank Taylor

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09552	
BIRTH NO. 66 09552		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <del>SPILLMAN</del> MORRIS SPILLMAN		2. DATE AND HOUR OF DEATH 9/20/1966 8: A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital of Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 3206 Carlisle Ave	
5. SEX male	6. RACE white	7. <del>MARRIED</del> NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 1/11/1890	9. AGE (In years last birthday) 76	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY <del>BALTIMORE</del> NONE		11. BIRTHPLACE (State or foreign country) <del>BALTIMORE</del> BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME JACOB SPILLMAN		14. MOTHER'S MAIDEN NAME ESTHER ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-50-9371		17. INFORMANT MD. IRVIN TOOR, 3206 CARLISLE AVENUE #16	
18. # 34.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Congestive heart failure (B) DUE TO Uremia (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 9/18/66 to 9/20/66 that (X) (we) last saw the deceased alive on 9/19/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. Rejate		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/20/1966	
23C. PHYSICIAN'S NAME (Type) I. REJATE		23D. ADDRESS M.D. LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/22/66		24C. NAME of CEMETERY or CREMATORY AITZ CHAIN-ANSHE EMINAH	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. SEP 22 1966			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN			



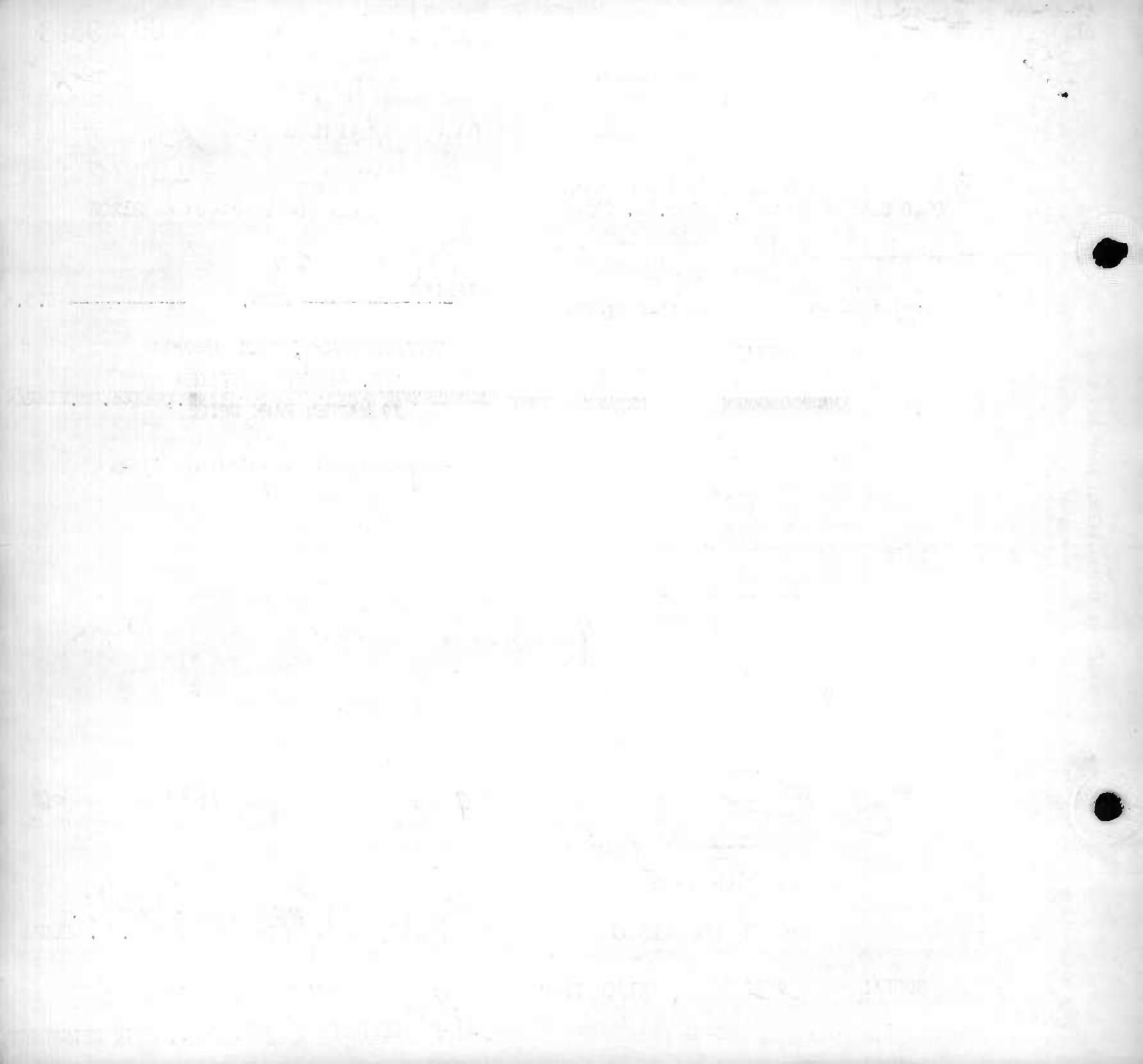


47-42-20  
NIW

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09553	
BIRTH NO. 66 09553				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Sidney Gottlieb	
2. DATE AND HOUR OF DEATH 9/20/66 6:00 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hosps. 4940 EASTERN AVENUE, Balto. Md. 21224				A. STATE Md. B. COUNTY Baltimore	
5. SEX male				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 33-00	
6. RACE white				D. STREET ADDRESS (If rural, give location) 29 Warren Park Drive . 21208	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married				8. DATE OF BIRTH 6/9/07	
9. AGE (in years lost birthday) 59				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) upholsterer	
11. BIRTHPLACE (State or foreign country) STEELTON, PENN.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John GOTTLIEB				14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SECURITY NO. XXXXXXXXXXXXXXXXXX	
17. INFORMANT MRS. ALBERTA GOTTLIEB ADDRESS 29 WARREN PARK DRIVE					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH	
ANTECEDENT CAUSES				INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) acute myocardial infarction 2 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Parkinson's Disease 10 yrs.	
19A. DATE OF OPERATION 9/20/66				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/9/66 to 9/20/66, that (I) (we) last saw the deceased alive on 9/20/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce M. Dow				23B. DATE SIGNED 9/20/66	
23C. PHYSICIAN'S NAME (Type) Bruce M. Dow				23D. ADDRESS Balto. City Hosps. 4940 Eastern Avenue, Balto. Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 9/21/66	
24C. NAME OF CEMETERY or CREMATORY PETACH TIKVAH				24D. LOCATION BALTIMORE, MARYLAND	
25A. DATE BY HEALTH DEPT. SEP 22 1966				25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR LEVINSON & BROS. INC., 6010 REISTERST				ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09554		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 09554	
M.E. CASE NO.		1. NAME OF DECEASED DOROTHY Evelyn Engel		2. DATE AND HOUR OF DEATH 19 Sept 66 11:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3220 Bluehill Rd			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 10-28-18	9. AGE (In years lost birthday) 47	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) PORTSMOUTH Virginia	
13. FATHER'S NAME Bernard L. Resh		14. MOTHER'S MAIDEN NAME FRIEDA Lichtenstein		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-09-5232		17. INFORMATION ADDRESS MR. HARRY ENGEL, 3220 BLUE HILL ROAD #7	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 296X-1		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Post-op Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 7 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 13 Sept 66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hemorrhage		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12 Sept 1966 to 19 Sept 1966, that (I) (we) last saw the deceased alive on 19 Sept 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard Berkowitz M.D.				23B. DATE SIGNED 19 Sept 66	
23C. PHYSICIAN'S NAME (Type) Richard Berkowitz M.D.		23D. ADDRESS Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/20/66		24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAH (AITZ CHAIN)	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE RECEIVED BY HEALTH DEPT. SEP 22 1966			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN			

10/6/66 - Post op Hemorrhage  
Sepsis  
Blood Incoagulability  
(Hypofibrinogenemia)  
Letter from Linn Hosp - Filed in Bur. of Biostatistics  
American Bd of

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09555		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09555	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MILLER, SAMUEL H. JR.		2. DATE AND HOUR OF DEATH SEPT. 19, 1966		6:35 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. CO.			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON AND WILKENS AVENUES, BALTIMORE, MARYLAND 21229		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21228		D. STREET ADDRESS (If rural, give location) 13 NORTH BEAUMONT AVENUE	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-06-19	9. AGE (In years last birthday) 46	If Under 1 Tr. Months: If Under 24 Hrs. Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10B. KIND OF BUSINESS OR INDUSTRY JEWELRY STORE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME SAMUEL MILLER (DEC'D)		14. MOTHER'S MAIDEN NAME MARY L GARISH (DEC'D)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220 03 4704		17. INFORMANT ADDRESS HOSPITAL SLIP -ST. AGNES HOSPITAL	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Specialized puerperal (B) Recurrent Sideritis (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Wound Abscess					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from AUGUST 26, 1966 to SEPT. 19, 1966, that (X) (we) last saw the deceased alive on SEPTEMBER 19, 1966 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. DEL ROSARIO, M.D.		23B. DATE SIGNED 9-20-66		23C. PHYSICIAN'S NAME (Type) R. DEL ROSARIO, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE		24C. NAME OF CEMETERY or CREMATORY Louden Pk. Cemetery	
24D. LOCATION (City, town, or county) BALTIMORE Md.		24E. FUNERAL DIRECTOR E. S. MacNabb		24F. ADDRESS CATONSVILLE Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR E. S. MacNabb	

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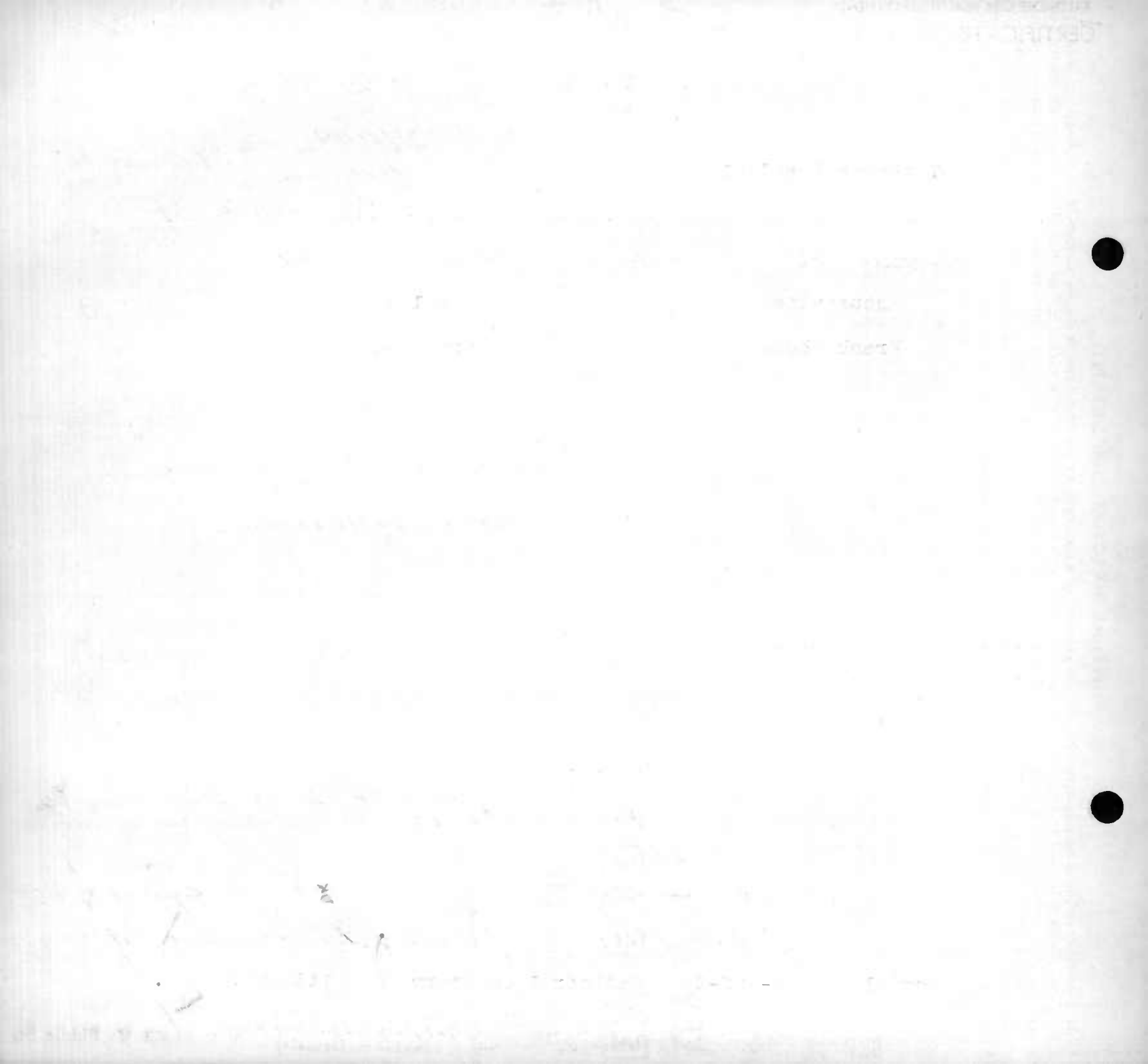
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**FUNERAL DIRECTOR: IMPORTANT**

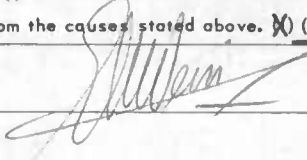
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 09556	
BIRTH NO. 66 09556		<b>CERTIFICATE OF DEATH</b>		Registered No. 66 09556	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Mrs. Helen Hicks</i>		2. DATE AND HOUR OF DEATH <i>8:45 9/18/66</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>16-05</i> D. STREET ADDRESS (If rural, give location) <i>2422 W. Lanvale St.</i>			
5. SEX <i>Female</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>4/11/1892</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Frank Thomas</i>			14. MOTHER'S MAIDEN NAME <i>Mary Wood</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Daughter</i>	
18. <i>293 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Congestive Heart Failure</i> DUE TO (B) <i>Severe Anemia</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8:00 a.m. 9/18/66</i> to <i>8:40 a.m. 9/18/66</i> , that (I) (we) last saw the deceased alive on <i>8:00 a.m. 9/18/66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Co. [Signature]</i>				23B. DATE SIGNED <i>Sept. 18. '66</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOHN SA KIM</i>		23D. ADDRESS <i>Lutheran Hosp. of Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>9-22-66</i>	24C. NAME OF CEMETERY or CREMATORY <i>Cathedral Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Talbot</i>		25C. FUNERAL DIRECTOR <i>Matthew A. Hensley</i> (Mrs) Frances A. Hensley	
ADDRESS <i>16 W. Biddle St.</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09557				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 66 09557	
1. NAME OF DECEASED (Type or Print) JUNIUS E CARTER				2. DATE AND HOUR OF DEATH 9 16 66 10:20A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL WILKENS & CATON BALTO 29 MD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Howard C. CITY OR TOWN (If outside city limits, write RURAL and give township) JESSUPS D. STREET ADDRESS (If rural, give location) BOX 176 OAKLAND MILLS RD			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8 9 17	9. AGE (In years lost birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME SAMUEL			14. MOTHER'S MAIDEN NAME NORA KELLY				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST AGNES HOSP RECORDS		
18. 330X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Rt Hemiplegia DUE TO (B) Subarachnoid Hemorrhage DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 9 16 1966 to 9 16 1966, and that (we) last saw the deceased alive on 9 16 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9 16 66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, (Specify)		24B. DATE 9-20-66		24C. NAME OF CEMETERY or CREMATORY 1st. Baptist Church.,		24D. LOCATION (City, town, or county) (State) Guilford, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR George R. Snowden		ADDRESS Rockville, Md.	

10:30A

10:30A

W. RYLAND

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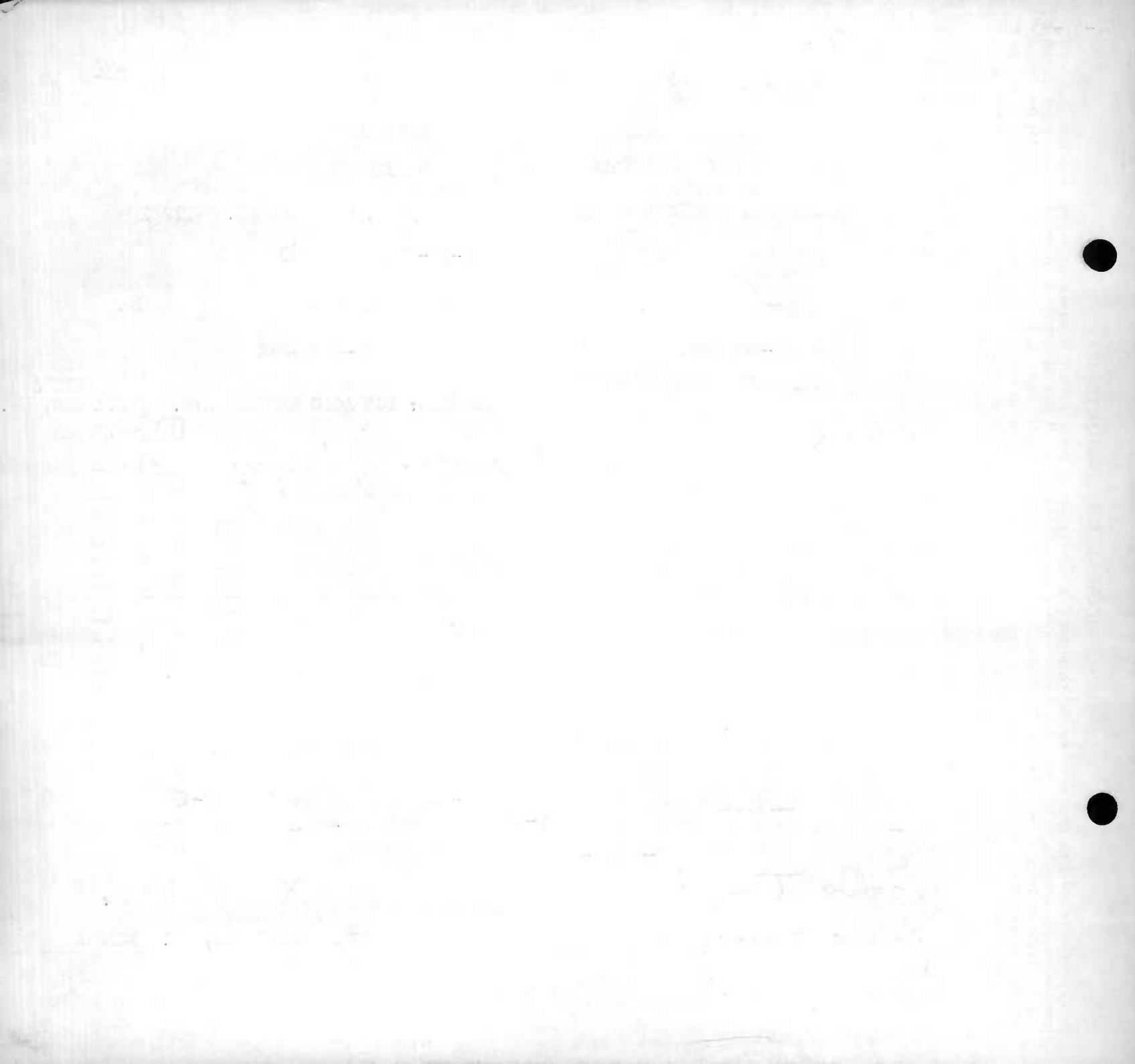
10:30A



47-69-95 DH  
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 66 09558		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09558	
M.E. CASE NO. 47-69-95		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GREEN WILLIAM		2. DATE AND HOUR OF DEATH 9-19-66 16 40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 36 N. CAROLINE ST. #21231			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-19-03	9. AGE (In years lost birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JAMES-deceased		14. MOTHER'S MAIDEN NAME CARRIE-deceased		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH 4940 EASTERN AVE. BALTIMORE, MD.		ADDRESS #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of Larynx DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-12 19 66 to 9-19 19 66, that (I) (we) lost saw the deceased alive on 9-19 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE x [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/19/66	
23C. PHYSICIAN'S NAME (Type) PABLO TREFOLCI		23D. ADDRESS M.D. BCH 4940 EASTERN AVENUE BALTIMORE, MD. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-23-66		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cmt	
24D. LOCATION (City, town, or county) (State) Brooklyn Md		25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR * 25D. ADDRESS			
SEP 22 1966 [Signature] [Signature] [Signature]					



H-125

66 09559

BALTIMORE CITY HEALTH DEPARTMENT

66 09559

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

William Hobson

2. DATE AND HOUR PRONOUNCED DEAD

9/20/66

12:25 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1334 Argyle Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1334 Argyle Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4-6-1892

9. AGE (In years  
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, when if retired)

Painted

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pidgeon Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Walter Hobson

14. MOTHER'S MAIDEN NAME

Mamie Grier

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL  
SECURITY NO.

217-14-6042

17. INFORMANT

ADDRESS

Winifred Hobson 1317 Upton St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/20/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

# VALLEY FORCE

REPORT

DATE

TIME

PLACE

REASON

RESULT

REMARKS

OFFICER

WITNESSES

REMARKS

REMARKS

REMARKS

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66 09560

BALTIMORE CITY HEALTH DEPARTMENT

66 09560

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOANNE C. SADLER

2. DATE AND HOUR PRONOUNCED DEAD

September 16, 1966 8:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4623 Schenley Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 31, 1932

9. AGE (In years  
last birthday)

35

If Under 1 Yr. II Under 24 Hrs.  
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Supervisor

10B. KIND OF BUSINESS OR INDUSTRY

Advertising

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Harry B. Sadler 4623 Schenley Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Toxemia  
DUE TOANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Intravascular Hemolysin  
DUE TO

(C) Self-Inflicted Abortion.

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

4623 Schenley Road

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
9 14 '66

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Self-Inflicted Abortion.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/17/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9/20/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

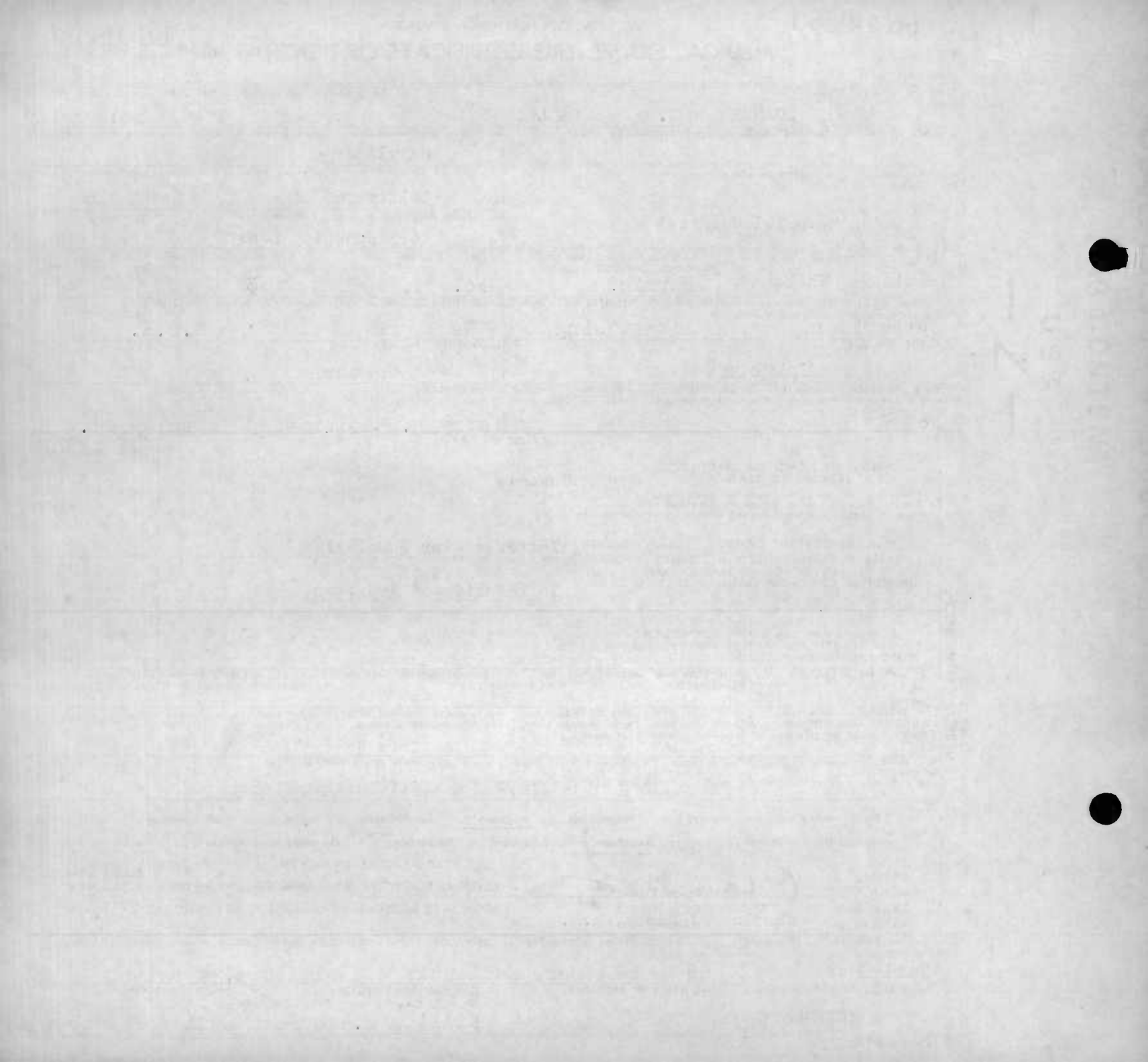
24C. FUNERAL DIRECTOR

ADDRESS

SEP 22 1966

Robert E. Farber, M.D.

William E. Johnson 8521 Loch Raven Bay

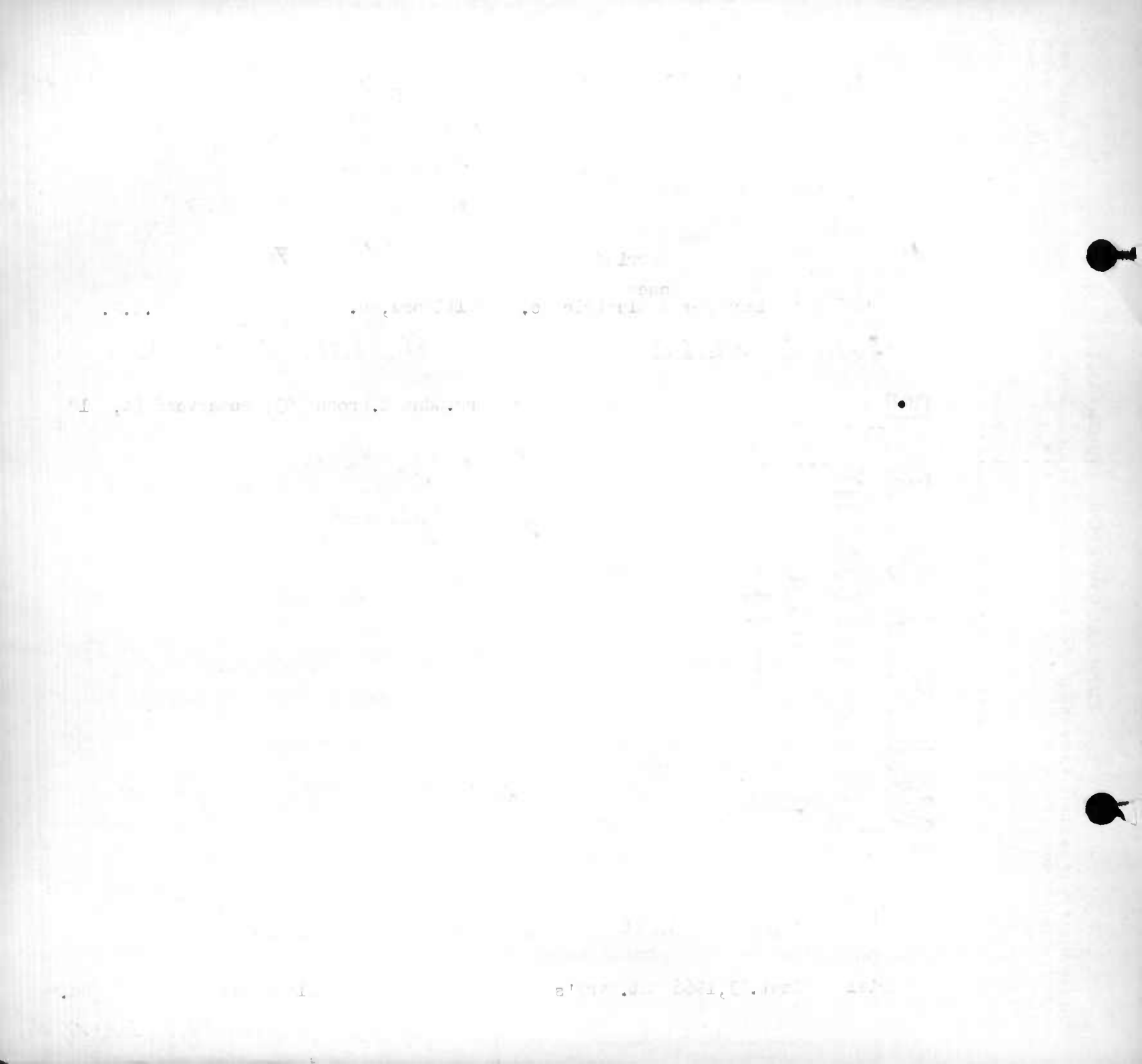




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09561		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09561	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) RAYMOND WHELKER BROWN		2. DATE AND HOUR OF DEATH September 20, 1966 4:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 937 Homestead Street			
5. SEX M	6. RACE W	7. <del>MARRIED</del> NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH May 1, 1896	9. AGE (In years lost birthday) 70	10. Under 1 Yr. Months Days 10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10B. KIND OF BUSINESS OR INDUSTRY Power Gas & Electric Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Frederick Whelker		14. MOTHER'S MAIDEN NAME Elizabeth Peacock		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212 05 5659		17. INFORMANT ADDRESS Mrs. Edna C. Brown 937 Homestead St, 18	
18. 745 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic CO <sub>2</sub> narcosis Severe Chronic Pulmonary Emphysema Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Severe kypho-scoliosis, acquired		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 16 19 66 to Sept. 20 19 66, that (I) (we) last saw the deceased alive on Sept. 20 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE NIEVA G. VALLE M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED September 20, 1966	
23C. PHYSICIAN'S NAME (Type) NIEVA G. VALLE				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 23, 1966		24C. NAME OF CEMETERY or CREMATORY St. Mary's	
24D. LOCATION Silver Run		24E. (City, town, or county) Md.		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. J. Tucker & Sons, 17 Pa. Ave. S.W.	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 09562		CERTIFICATE OF DEATH		Registered No. 66 09562	
1. NAME OF DECEASED (Type or Print) <b>Glen W. Stiehm</b>				2. DATE AND HOUR OF DEATH <b>Sept. 19, 1966</b>		(Unknown) M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>874 Tyson Street</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>874 Tyson St.</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Divorced</b>	8. DATE OF BIRTH <b>Jan 6, 1915</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Placement Director</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>University of Balto.</b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William H. Stiehm</b>				14. MOTHER'S MAIDEN NAME <b>Hattie Hoene</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Coronary thrombosis</b> DUE TO (B) <b>A-S heart disease</b> DUE TO (C) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>—</b> <b>2.5 yrs</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (the hospital) attended the deceased from <b>Jan 1958</b> to <b>Sept 19 1966</b> , that (I) <del>was</del> last saw the deceased alive on <b>Sept 17 1966</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did not) view the body after death.									
23A. SIGNATURE <b>N.R. Freeman Jr.</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9/20/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>N.R. Freeman Jr.</b>				23D. ADDRESS <b>11 W. 29th St.</b>					
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/21/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairman</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Dickner</b>		ADDRESS <b>Long &amp; Penna Ave North &amp; Penna Ave</b>			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 09563		REGISTERED NO. 66 09563	
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Pierson, William Virgil, Jr.</b>				<b>2. DATE AND HOUR OF DEATH</b> <b>September 21, 1966</b> <b>6:00 A.M.</b>			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd.</b> <b>Baltimore, Maryland 21218</b>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> <b>5. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>Baltimore</b> <b>6. STREET ADDRESS</b> (If rural, give location) <b>8 Cedar Ave</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>9/22/11</b>	<b>9. AGE</b> (In years lost birthday) <b>54</b>	<b>10. IF UNDER 1 Yr. Months</b> <b>11. IF UNDER 24 Hrs. Days</b> <b>12. IF UNDER 24 Hrs. Hours</b> <b>13. IF UNDER 24 Hrs. Min.</b>		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Paper Company</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>			
<b>13. FATHER'S NAME</b> <b>William V. Pierson, Sr.</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Julia Ammidon</b>				
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>9/8/42 - 4/21/46</b>		<b>16. SOCIAL SECURITY NO.</b> <b>562-18-8016</b>		<b>17. INFORMANT ADDRESS</b> <b>3900 Loch Raven Boulevard</b> <b>VA Hospital Records, Baltimore, Maryland 21218</b>			
<b>18. CAUSE OF DEATH</b> <b>1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>2. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>3. INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 1/2 years</b>			
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b> <b>II</b>							
<b>19A. DATE OF OPERATION</b> <b>2</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>Yes</b>			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (1) (this hospital) attended the deceased from September 15th 19 66 to September 21st 19 66, that (1) (we) last saw the deceased alive on September 21st 19 66 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <b>Donald H. Hooker</b>				<b>23B. DATE SIGNED</b> <b>September 21, 1966</b>			
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>DONALD H. HOOKER</b>		<b>23D. ADDRESS</b> <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard Balto., Md., 21218</b>					
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>24B. DATE</b> <b>9/23/66</b>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>ARLINGTON NATIONAL</b>			
<b>24D. LOCATION</b> (City, town, or county) (State) <b>FORT MYER, VIRGINIA</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>SEP 22 1966</b>					
<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor, MA</b>		<b>25C. FUNERAL DIRECTOR ADDRESS</b> <b>Stewart &amp; Mowen Co., 108 W. North Av/City</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09564</u>	
BIRTH NO. <u>66 09564</u>		<b>CERTIFICATE OF DEATH</b>		2. DATE AND HOUR OF DEATH <u>9-20-66 6:50 PM</u> M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Annie Schuler</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hospital</u>		(If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
5. SEX <u>F</u>		6. RACE <u>Caucasian</u>		7. MARRIED, <del>NEVER MARRIED</del> WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		8. DATE OF BIRTH <u>05/05/99</u>	
13. FATHER'S NAME <u>George Schuler</u>		14. MOTHER'S MAIDEN NAME <u>Margdalene Biers</u>		9. AGE (In years last birthday) <u>67</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-54-9344</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
18. <u>156.21</u>		CAUSE OF DEATH		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <u>metastatic Liver Cancer (?)</u>		ADDRESS <u>2813 Erdman Ave. Md</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>primary origin unknown</u>		INTERVAL BETWEEN ONSET AND DEATH	
(C) _____					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Large ventral hernia incarcerated</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Shen Shu-say</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-20-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>SHEN-SHUT TSENG</u>		23D. ADDRESS <u>Union Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<u>Burial</u>		<u>Sept 23rd</u>		<u>Holy Redeemer</u>	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
<u>Baltimore</u>		<u>Md</u>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<u>SEP 22 1966</u>		<u>Robert E. Fanning</u>		<u>Philip Herwig, Inc</u>	
				ADDRESS <u>2813 Erdman Ave</u>	



66 09565

BALTIMORE CITY HEALTH DEPARTMENT

66 09565

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ANITA

E.

HARCHENHORN

2. DATE AND HOUR PRONOUNCED DEAD

September 18, 1966

5:40 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4112 E. Eager Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 21/1918

9. AGE (In years  
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Penn.

12. CITIZEN OF  
WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

Hubert Bayner

14. MOTHER'S MAIDEN NAME

Marie Nolte

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

Mrs. Hillery Harchenhorn

ADDRESS

4112

E. Eager St

18.

420.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/18/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

23B. DATE

Sept 18/66

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

Pen Argyl Penna.

24A. DATE REC'D BY HEALTH DEPT.

SEP 22 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Phyllis Herwig, Sons

ADDRESS

2624  
Carleant St

WALTON'S FOREIGN



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W-452

66 09566

BALTIMORE CITY HEALTH DEPARTMENT

66 09566

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		ROBERT WILLIAMS		2. DATE AND HOUR PRONOUNCED DEAD		September 18, 1966 6:30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland			
43 South Baltimore General Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-06			
D. STREET ADDRESS (If rural, give location) 3210 Tate Street							
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.		
Male	Negro		8/15/38	28			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer				South Carolina		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Robert Williams				Janie Durant			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
				Janie Williams Mannings, S.C.			
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)							
(A) Subdural Hematoma.							
DUE TO							
(B) DUE TO							
(C) DUE TO							
INTERVAL BETWEEN ONSET AND DEATH							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
		Home		3210 Tate Street 25-06			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
9 16 '66 P		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Probable fall.			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
Charles S. Petty		Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		9/18/66	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		9/25/66		Chapel Cemetery		Mannings, S.C.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
SEP 22 1966		Robert E. Taylor, M.D.		Charles A. Rice		661 W. Barre St.	

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66 09567

BALTIMORE CITY HEALTH DEPARTMENT

66 09567

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN LEE EDWARDS

2. DATE AND HOUR PRONOUNCED DEAD

September 14, 1966 5:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

512 Robert Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

2-5-08

9. AGE (in years  
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PARKING ATTEND

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIDELIA GA.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

24-12-4489

17. INFORMANT

ADDRESS

Mrs FANNIE GAMBRELL 2919 Parkwood Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Fatty Liver.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/15/66

23A. BURIAL CREMATION  
REMOVAL (Specify)

Burial

23B. DATE

9-21-66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

23D. LOCATION (City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 22 1966

24B. NAME OF REGISTRAR

Robert E. Fawcett

24C. FUNERAL DIRECTOR

Joseph L. Russ 2222 W. North Ave  
Baltimore, Md.

ADDRESS

WALTER BOWEN

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09568

1. NAME OF DECEASED

(Type or Print)

Bruce Schaefer

2. DATE AND HOUR PRONOUNCED DEAD

9/19/66 8:10 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6641 Dogwood Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Never married

8. DATE OF BIRTH

Aug. 11, 1946

9. AGE (In years  
last birthday)

20

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

serviceman

10B. KIND OF BUSINESS OR INDUSTRY

Patco Ref. Co.

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Eric F. Schaefer

14. MOTHER'S MAIDEN NAME

Eleanor Mowery

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

216-44-2012

17. INFORMANT

Mr. Eric Schaefer

ADDRESS

6641 Dogwood Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Electrocution

(A).....  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B).....  
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

house

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

5112 Windsor Mill Rd.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
9 19 66 7:30p.m.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

electrocuted while repairing washing  
machine

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/20/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

9-23-66

23B. DATE

9-23-66

23C. NAME of CEMETERY or CREMATORY

Woodlawn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 22 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Witzke F.D.-4101 Edmondson Ave.

ADDRESS

WALTER POLICE



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 09569</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>66 09569</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Walter Butz</b>			2. DATE AND HOUR OF DEATH <b>Sept. 19, 1966</b> <span style="float: right;">M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>5115 Queensberry Ave. Baltimore, 15, Md.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>27-17</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>5115 Queensberry Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>Wh</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 2, 1894</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Letter carrier</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Postal Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Evelyn Butz</b> <b>5115 Queensberry Ave. - #15</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>163X I</b> <b>Carcinoma of lung</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>June 28, 1966</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 28</b> 19 <b>66</b> to <b>September 18</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>September 18</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Raphael A. Perez-Mera</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Raphael A. Perez-Mera</b>				23D. ADDRESS <b>7306 Liberty Rd.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> <b>9-22-66</b>		24B. DATE <b>9-22-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cem.</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Witzke, F.D. - 4101 Edmondson Ave.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09570		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09570	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JAMES THOMAS Dorsey		2. DATE AND HOUR OF DEATH 9-21-66 11:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 16-07 D. STREET ADDRESS (If rural, give location) 3004 W PRESSTMAN ST.			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 3/25/92	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME JOHN DORSEY		14. MOTHER'S MAIDEN NAME MARY BEAL		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT MRS AGNES MURRAY		ADDRESS 3004 Presstman	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I Thrombosis of the superior vena cava Dehydration & septicemia Generalized peritonitis due to perforated ca of the cecum		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 9-19-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Peritonitis	
19C. DATE OF OPERATION 9-19-66		19D. CONDITION FOR WHICH OPERATION WAS PERFORMED Peritonitis		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-18-66 to 9-21-66, that (I) (we) lost saw the deceased alive on 9-21-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE J. Thomas		23B. DATE SIGNED 22 Sept 66	
23C. PHYSICIAN'S NAME (Type) M.D.		23D. ADDRESS M.D.		23E. DATE SIGNED 22 Sept 66	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/24/66		24C. NAME OF CEMETERY or CREMATORY HOLY FAMILY CEM	
24D. LOCATION HARRISONVILLE MD.		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR W.M.C. MARCH	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR W.M.C. MARCH	
24J. DATE REC'D BY HEALTH DEPT.		24K. NAME OF REGISTRAR		24L. FUNERAL DIRECTOR W.M.C. MARCH	
24M. DATE REC'D BY HEALTH DEPT.		24N. NAME OF REGISTRAR		24O. FUNERAL DIRECTOR W.M.C. MARCH	

2

234

254

Abstract

5-7

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09571				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 09571	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Kozlowski, James</b> (Or Stanislaus)		2. DATE AND HOUR OF DEATH <b>9-21-66 @ 5:50 pm</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore, Maryland</b> D. STREET ADDRESS <b>523 N. Linwood Ave</b> (If rural, give location) <b>7-01</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>				(If not in hospital or institution, give street address or location)					
5. SEX <b>W</b>	6. RACE <b>M</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>5-5-11</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Clerk</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Frank Komlawski</b>				14. MOTHER'S MAIDEN NAME <b>Adele Jankiewicz</b>					
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>218-10-0182</b>		17. INFORMANT <b>Mrs. Frances Kozlowski</b>			
				ADDRESS <b>523 N. Linwood Ave</b>					
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Vascular Accident</b>				CAUSE OF DEATH (A) DUE TO <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hr.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <b>9/21</b> <b>19 66</b> to <b>9/21</b> <b>19 66</b> , that (1) (we) last saw the deceased alive on <b>9/21</b> <b>19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>C. H. Brown, III</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9/21/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>C. H. BROWN 444</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/24/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Stanislaus Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>George A. Weber</b>		ADDRESS <b>705 South Ann Street</b>			

12-10-1911

John H. H. H. H.

W M M

Frank Kampmann

2-5-11

82

223 N. Lincoln Ave.  
Baltimore, Md.

BALTIMORE CITY HEALTH DEPARTMENT

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) AKA Grefous 2. DATE AND HOUR PRONOUNCED DEAD  
GERSOUS BENNETT September 20, 1966 6:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
 A. STATE Maryland B. COUNTY \_\_\_\_\_

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
39 Provident Hospital Baltimore

D. STREET ADDRESS (If rural, give location)  
1802 Etting Street

5. SEX Male 6. RACE Colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED 8. DATE OF BIRTH 1-10-21 9. AGE (In years last birthday) 45 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?  
Shipyard Worker Md. Drydock EASTON MARYLAND U.S.A.

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME  
John Bennett Mary Stanley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS  
YES WWII 12-31-43 - 1-18-44 217-16-9393 IRMA BENNETT 1802 ETTING ST.

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
(A) Arteriosclerotic Cardiovascular Disease  
 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
 (B) DUE TO \_\_\_\_\_  
 (C) \_\_\_\_\_

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
 \_\_\_\_\_

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?  
 \_\_\_\_\_

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
 ACTUAL SIGNATURE Rudiger Breiteneker CHIEF MEDICAL EXAMINER ☐  
 EXAMINER'S NAME (Type) Rudiger Breiteneker ASSISTANT MEDICAL EXAMINER ☒  
 ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 9/21/66

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 9-26-66 23C. NAME of CEMETERY or CREMATORY Balto. National 23D. LOCATION (City, town, or county) (State) Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT. SEP 22 1966 24B. NAME OF REGISTRAR Robert E. Farley 24C. FUNERAL DIRECTOR ADDRESS Joseph L. Parn 2222 W. North Ave

WALLACE FORBES

RECEIVED

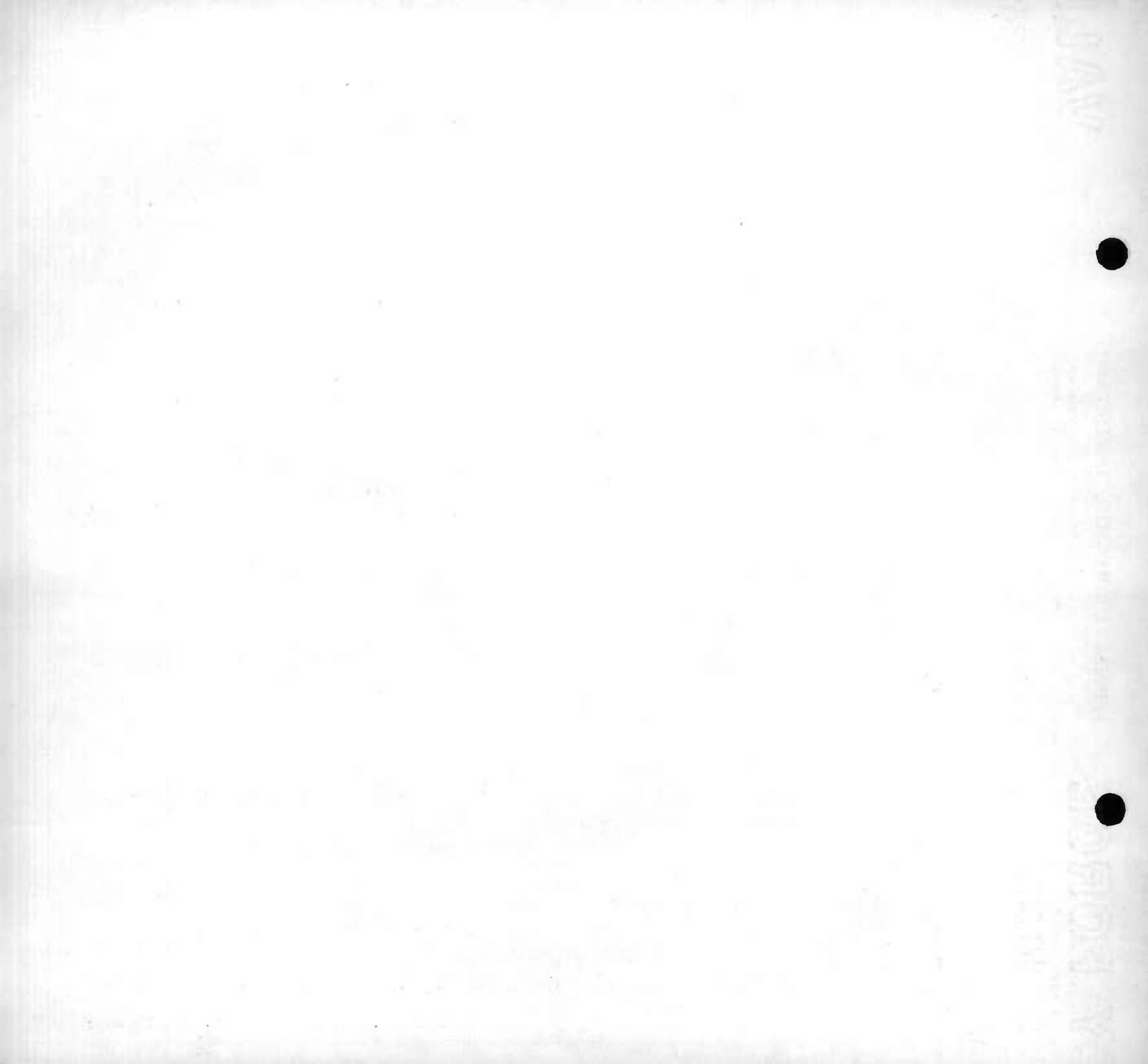
1907

WALLACE FORBES

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 09573</span>	
BIRTH NO. <span style="float: right;">66 09573</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Lottie Sheppard</b>		2. DATE AND HOUR OF DEATH <b>Sept. 21, 1966</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>519 Robert Street</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>519 Robert Street</b>			
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>May 13, 1879</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Hanover Co. Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Spencer Brown</b>		14. MOTHER'S MAIDEN NAME <b>Ella White</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Iretha Brown -519 Robert Street</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  <b>Arteriosclerotic Heart Disease</b>		CAUSE OF DEATH (A) DUE TO <b>Arteriosclerotic Heart Disease</b> (B) DUE TO <b>Acute Gastro Enteritis</b> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b>2 yrs</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-7-66</b> 19 to <b>9-21-66</b> 19, that (I) (we) last saw the deceased alive on <b>9-21-66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>G. Franklin Phillips</b>				23B. DATE SIGNED <b>9/22/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>G. Franklin Phillips</b>		23D. ADDRESS <b>558 McMoran St Baltimore</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/24/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Family Lot Ebermezer Bapt. Cem.</b>	
24D. LOCATION <b>Ashland Co. Va -Hanover Va</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>Herbert E. Nutter</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter-3035 W. North Ave.</b>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09574</u>	
BIRTH NO. <u>66 09574</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>1</u>		1. NAME OF DECEASED (Type or Print) <u>RubINETTE Delaware</u>		2. DATE AND HOUR OF DEATH <u>9-19-66</u>   <u>9:05 a.m.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
D. STREET ADDRESS (If rural, give location) <u>1222 Bentalou Street</u>		16-05			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 29, 1888</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>		11. BIRTHPLACE (State or foreign country) <u>Essex County, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Bundy</u>			
14. MOTHER'S MAIDEN NAME <u>Nannie Taylor</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Susie Robinson (Niece)</u>		ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>260X I</u>		CAUSE OF DEATH (A) DUE TO <u>Electrolyte imbalance</u> (B) DUE TO <u>Diabetic mellitus</u> (C) <u>Gangren of right foot</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>August 5, 1966</u> to <u>September 19, 1966</u> , that (I) (we) last saw the deceased alive on <u>September 19, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-20-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>C Laredo</u>		23D. ADDRESS M.D. <u>1514 Division Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/19/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Arbutus Balto Co Md</u>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Herbert E. Nutter 3035 W. North Ave</u>			

— *unpublished* —  
— *unpublished* —  
— *unpublished* —

66 09575

BALTIMORE CITY HEALTH DEPARTMENT

66 09575

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Collin H. Blackwell

2. DATE AND HOUR PRONOUNCED DEAD

9/20/66 12:30 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2634 Garrett Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

June 14, 1896

9. AGE (In years  
lost birthday)

70

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

Victoria VA.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

STEVEN Blackwell

14. MOTHER'S MAIDEN NAME

UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

UNK.

16. SOCIAL  
SECURITY NO.

216-10-2100

17. INFORMANT

May Blackwell

ADDRESS

2634 GARRETT AVE.

18. 4221 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/20/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

9-24-66

23C. NAME OF CEMETERY or CREMATORY

MT. CALVARY

23D. LOCATION

A.A. Co

(City, town, or county)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 22 1966

D. G. E. F. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

MORTON + DyeIT

1701 LAURENS ST.

VALLEY FORGE

BIRTH NO.

66 09576

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Richard C. Cousins

2. DATE AND HOUR PRONOUNCED DEAD

9/19/66 5:25 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

60 503 N. Paca St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

503 N. Paca St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

11-14-1907

9. AGE (In years  
lost birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Laundry

11. BIRTHPLACE (State or foreign country)

Dinwiddie, VA.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Richard Cousins

14. MOTHER'S MAIDEN NAME

ANNA COUSIN'S

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

211-07-2452

17. INFORMANT

ADDRESS

Pauline Cousins 503 N. PACA.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/20/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9-23-66

23C. NAME of CEMETERY or CREMATORY

MT. Auburn

23D. LOCATION

(City, town, or county)

Balto.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 22 1966

Robert E. Fisher, M.D.

Morton + Dyett 1701 LAURENS ST.

VALLEY MOBILE

APR 10 1971

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09577</b>	
BIRTH NO. <b>66 09577</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>Lillie M. Scott</b>			2. DATE AND HOUR OF DEATH <b>9-19-66 2.08AM</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Jenkins Memorial Hospital</b> <i>91 1000 Caton Ave. 21229</i>			A. STATE <b>Md.</b> B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>319 Tuscany Road</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>10-6-76</b>	9. AGE (In years last birthday) <b>89</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>James H. McFee</b>			14. MOTHER'S MAIDEN NAME <b>Virginia Bondelle</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-32-7460</b>		17. INFORMANT <b>Sister Mary Cyril, Jenkins Memorial Hosp.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>443X I</b>			CAUSE OF DEATH (A) DUE TO <b>Cuba Vaccines Accident 4 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			(B) DUE TO <b>AHWD</b>		<b>years</b>
			(C) <b>See Antecedent causes</b>		<b>year</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-11-62</b> 19 to <b>9-19</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9-17</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Samuel J. [Signature]</i>				23B. DATE SIGNED <b>9-15-66</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<b>Burial</b>		<b>Sep 21/66</b>		<b>Woodlawn</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>SEP 22 1966</b>		<b>Robert E. [Signature]</b>		<b>Stewart [Signature]</b>	
25D. ADDRESS <b>108 W 4th St</b>					





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09578</u>	
BIRTH NO. <u>66 09578</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Thomas J. McGrath, Jr.</u>		2. DATE AND HOUR OF DEATH <u>9/20/66</u> <u>10<sup>10</sup> A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital.</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>945 Argonne Drive</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>10/13/1908</u>	9. AGE (In years last birthday) <u>57</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Superior Court Baltimore City</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Patrick J. McGrath</u>		14. MOTHER'S MAIDEN NAME <u>Nora Driscoll</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Edith T. McGrath</u> (Same)	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Myocardial infarction</u> DUE TO (B) <u>Coronary artery occlusion</u> DUE TO (C) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours.</u> <u>3 hours.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>None</u>					
19A. DATE OF OPERATION <u>2 Nov 66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>No</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>None</u>		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>None</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>9/20 1966</u> to <u>9/20 1966</u> , that (I) (we) last saw the deceased alive on <u>9/20 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Philip B. Droskin</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>9/20/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Philip B. Droskin</u> M.D.				23D. ADDRESS <u>Mercy Hosp., Balto., Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/23/1966</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1966</u>		25B. NAME OF REGISTRAR <u>Philip B. Droskin</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md.</u>	

10/11

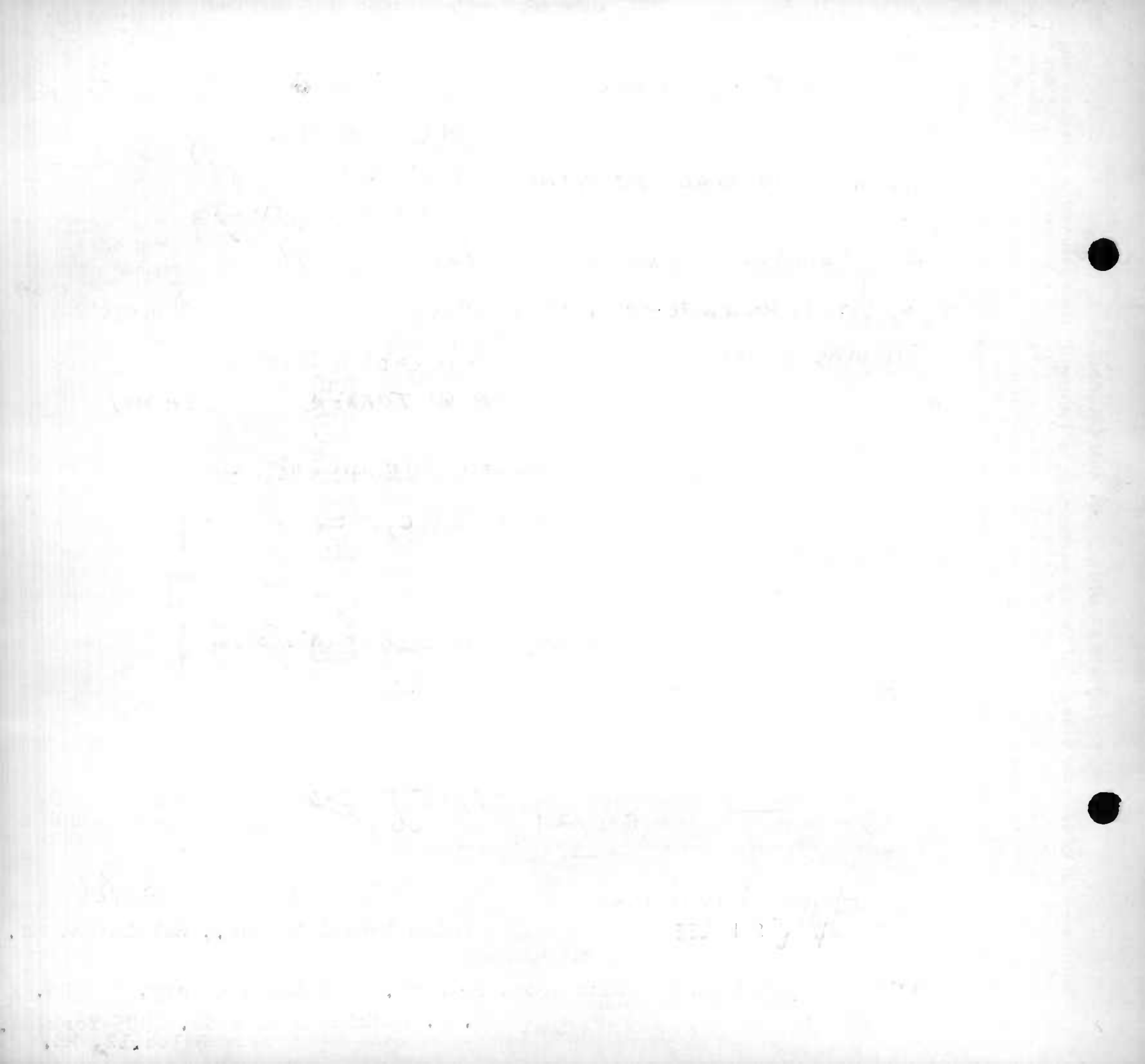
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09579	
<div style="display: flex; justify-content: space-between;"> <span>1-651</span> <span>66 09579</span> </div>					
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>Turner, Anna Haile</b>		2. DATE AND HOUR OF DEATH <b>09/21/66, 19.17 P.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b> <b>44</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3109 Abell Ave.</b>			
5. SEX <b>F.</b>	6. RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>10/24/89</b>	9. AGE (In years lost birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Housewife - Own Home</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. American</b>		13. FATHER'S NAME <b>Thomas J. Haile</b>			
14. MOTHER'S MAIDEN NAME <b>Elizabeth Slade</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>220-05-3708</b>		17. INFORMANT <b>A.W. TURNER (SAME)</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>385 X1</b>		CAUSE OF DEATH (A) <b>Possible Pulmonary Embolism</b> DUE TO (B) <b>Acute Cholecystitis</b> DUE TO (C) _____			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Degenerative Lesion Brain Stem</b>			
19A. DATE OF OPERATION <b>09/19/66</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute Cholecystitis</b>	20A. AUTOPSY? (Yes or No) <b>No.</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>09/15, 1966</b> to <b>09/21, 1966</b> , that (I) (we) last saw the deceased alive on <b>09/21, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Hyong Sok Lee</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>09/21/66</b>	
23C. PHYSICIAN NAME (Type) <b>HYONG SOK LEE</b>		23D. ADDRESS M.D. <b>Union Memorial Hosp., Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9/24/1966</b>	24C. NAME of CEMETERY or CREMATORY <b>Chestnut Grove Presbyt.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 09580		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09580	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				JANKUNAS, AMELIA K.A.	
2. DATE AND HOUR OF DEATH		9/20/66		10:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
ST. AGNES HOSPITAL CATON AND WILKENS AVENUE BALTIMORE, MARYLAND 21229			MARYLAND		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			BALTIMORE		
D. STREET ADDRESS (If rural, give location)			163 OAKLEE BX VILLAGE		
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
FEMALE		WHITE		WIDOWED	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11-01-78		87		NONE TAILORING	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
LITHUANIA		LITHUANIA		KACANAUSKAS (DEC'D)	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
UNKNOWN (DEC'D)		NO		215 03 5628	
17. INFORMANT		MISS BENEDICTINE JANKUNAS, SAME 4d HOSPITAL SLIP -ST. AGNES HOSPITAL			
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) DUE TO		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Acute Heart Failure with pulmonary edema		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Arteriosclerotic Heart Disease		
(C) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 10, 1966 to SEPTEMBER 19, 1966 that (X) (we) last saw the deceased alive on SEPTEMBER 19, 1966 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
MANUEL C. JIMENEZ				9-21-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. DATE SIGNED	
MANUEL C. JIMENEZ		ST. AGNES HOSPITAL -CATON & WILKENS AV			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		9-24-66		ST. STANISLAUS CEMETERY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 22 1966		R. L. E. Taylor		HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Coles

~~08128~~

Hutson

2. DATE AND HOUR PRONOUNCED DEAD

9/20/66 2:20 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

10-17-66

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Howard

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - rural Jessup, Md.

D. STREET ADDRESS (If rural, give location)

Box 4

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

5/20/16

9. AGE (In years  
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Parkway Manor Motel

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Samuel C. Hutson

14. MOTHER'S MAIDEN NAME

Mary Hudgins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

WWII

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Samuel C. Hutson, Redart, Va.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Gunshot wound of head

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

motel

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Washington-Baltimore Expwy., Jessup

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
9 ? 66 ?

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

shot in head

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/20/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9/22/66

23C. NAME OF CEMETERY or CREMATORY

St. Paul Cemetery

23D. LOCATION

(City, town, or county)

Susan, Va.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

HOWARD H. HUBBARD 4107 WILKENS AVE. 21229



Letter from M.E.'s office

10-17-66 M.H.

VALLEY POST



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09582		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09582	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>McIntire, Mr. Eddis EARL</i>		2. DATE AND HOUR OF DEATH <i>20 Sept 1966 13<sup>45</sup> A</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND )		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>MARYLAND General Hospital</i>		A. STATE <i>W. Va</i> B. COUNTY <i>V-45</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>New Martinsville</i>			
		D. STREET ADDRESS (If rural, give location) <i>326 Martin Ave</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>12/18/82</i>	9. AGE (In years last birthday) <i>83</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>W. Va</i>	
13. FATHER'S NAME <i>James McIntire</i>		14. MOTHER'S MAIDEN NAME <i>MARTHA HARRISON</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>232 073231</i>		17. INFORMANT <i>CHART</i>	
18. <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Renal Failure</i> DUE TO (B) <i>CVA</i> DUE TO (C) <i>ASCVD</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>3 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Abd. Aortic Aneurysm, Urinary Retention</i>					
19A. DATE OF OPERATION <i>16 Sept 66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Urinary Retention</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5 Sept 66</i> to <i>20 Sept 66</i> and that (I) (we) last saw the deceased alive on <i>20 Sept 66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Edward D. Payne</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>20 Sept 1966</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <i>9-23, 66</i>		24C. NAME OF CEMETERY or CREMATORY <b>GRAND VIEW CEMETERY, NEW MARTINSVILLE, WEST VIRGINIA</b>	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR ADDRESS <b>HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09583				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 09583	
1. NAME OF DECEASED (Type or Print) <u>Lum, Ernest</u>				2. DATE AND HOUR OF DEATH <u>9/18/66</u> <u>10 a.m.</u>					
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>AN</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u> <u>33</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>B7D-3</u> <u>Annapolis</u> <u>Md</u>					
				D. STREET ADDRESS (If rural, give location) <u>B7D-3</u> <u>52-00</u>					
5. SEX <u>MALE</u>	6. RACE <u>ORIENTAL</u>	7. <input checked="" type="checkbox"/> MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>3-3-12</u>	9. AGE (In years lost birthday) <u>54</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>High school</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Lum (dec.)</u>				14. MOTHER'S MAIDEN NAME <u>Mamie Munsley (dec.)</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>None</u> <u>None</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MARIA A. Lum - 120 4 St. N.W.</u> <u>Wife</u>			
18. <u>420.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>				(A) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO					
				(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>Sept 1</u> 19 <u>66</u> to <u>Sept 18</u> 19 <u>66</u> , that <u>(1)</u> (we) lost saw the deceased alive on <u>9:40 am Sept 18</u> 19 <u>66</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(1)</u> (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Tah-Hsiung Hsu</u> M.D.								23B. DATE SIGNED <u>9/18/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>TAH-HSIUNG HSU</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u> M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-24-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olivet Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>			
25A. DATE RECEIVED BY HEALTH DEPT. <u>SEP 22 1966</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>John T. Rhines Co., 3015 12th St., NE</u>			

MEDICAL CERTIFICATION



**FUNERAL DIRECTOR: IMPORTANT**

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09585</u>	
66 09585				CERTIFICATE OF DEATH	
BIRTH NO. <u>1470</u>		M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>19 SEPT 66 12:50 P.M.</u>	
1. NAME OF DECEASED (Type or Print) <u>WHEATLEY, LUTHER HAYES</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION MEMORIAL HOSP</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
				D. STREET ADDRESS (If rural, give location) <u>729 HOMESTEAD STREET</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>3-17-01</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER B.O.R.R. UNK</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>WHEATLEY, OSCAR</u>			14. MOTHER'S MAIDEN NAME <u>ANNIE SMITH</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unk No</u>			16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT ADDRESS <u>Mrs Gladys M. Wheatley, 729 Homestead St.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			(A) <u>Due to</u> <u>1) Bronchogenic Carcinoma, metastatic to</u>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) <u>liver, adrenal</u>		
II			2) <u>pulmonary edema</u> <u>41 K. Bin</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-11-</u> <u>1966</u> to <u>15 SEPT</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>19 SEPT</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sidney E. Kirkley</u> M.D.				23B. DATE SIGNED <u>19 SEPT 66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. SIDNEY E. KIRKLEY</u>				23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>9/22/66</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Washington</u>				24D. LOCATION (City, town, or county) (State) <u>Harlock, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1966</u>		25B. NAME OF REGISTRAR <u>R. E. E. Talley</u>		25C. FUNERAL DIRECTOR <u>Edw. Talley, East New Market, Md</u>	



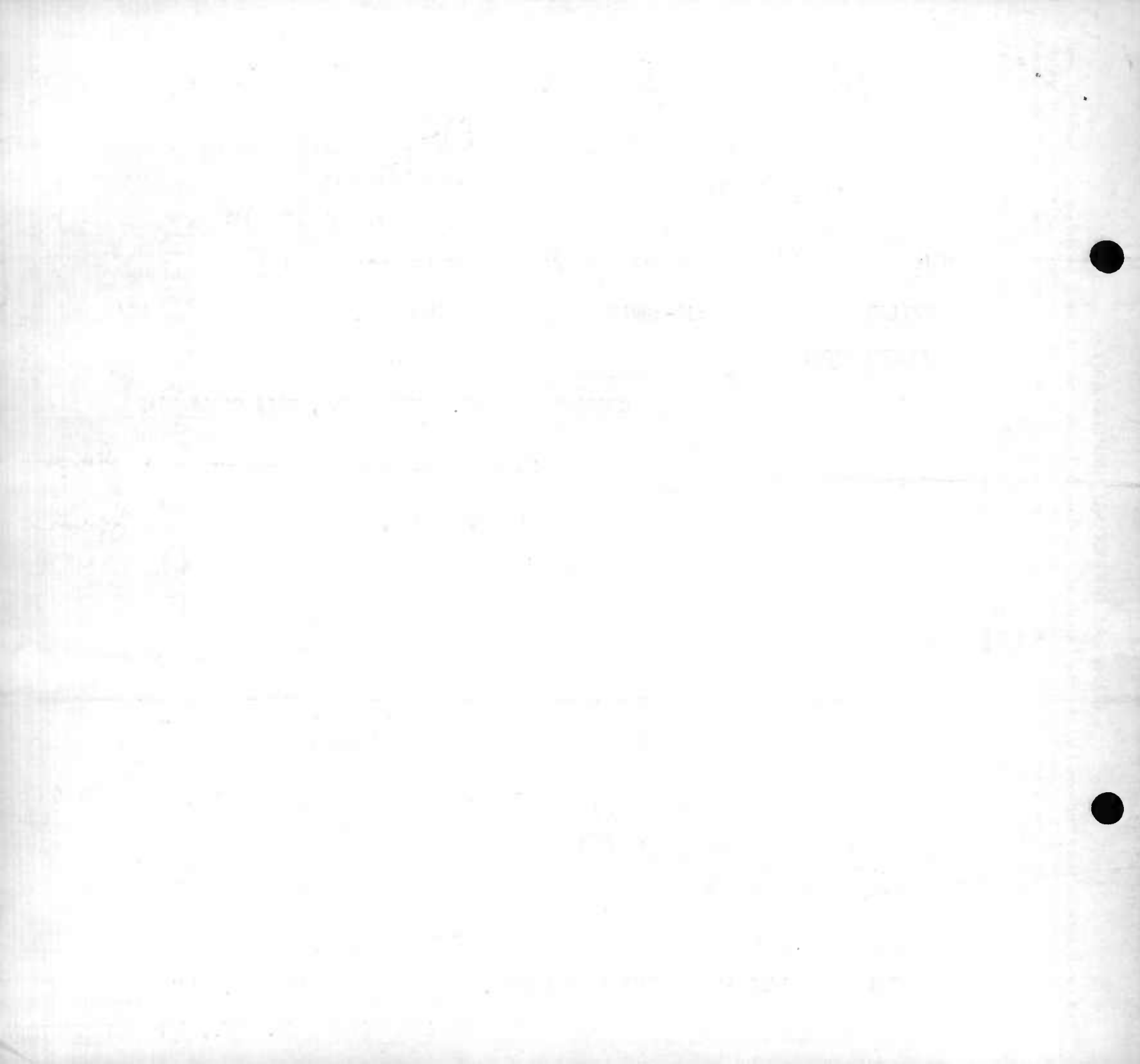
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09586
BIRTH NO. 66 09586		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MILTON SACHS</b>		2. DATE AND HOUR OF DEATH <b>9/20-66 6:25 P.M.</b>
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
		D. STREET ADDRESS (If rural, give location) <b>7618 Carla Rd</b>		
5. SEX <b>MALE</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>9/10/11</b>	9. AGE (In years last birthday) <b>55</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>
13. FATHER'S NAME <b>JOSEPH SACHS</b>		14. MOTHER'S MAIDEN NAME <b>RACHAEL ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>MRS. EDITH SACHS, 7618 CARLA ROAD</b>
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarct</b>		CAUSE OF DEATH (A) DUE TO <b>HASCD</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 years</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)
<b>II</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>9/18</b> 19 <b>66</b> to <b>9/20</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/20</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I) (We) (did)</b> (did not) view the body after death.				
23A. SIGNATURE <b>S. Gordon</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/20/66</b>
23C. PHYSICIAN'S NAME (Type) <b>S. GORDON</b>		23D. ADDRESS M.D. <b>SINAI HOSP</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>9/22/66</b>	24C. NAME of CEMETERY or CREMATORY <b>BNAI ISRAEL CONG.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</b>



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <span style="font-size: 1.5em;">66 09587</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 1.5em;">66 09587</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">IRVING SAX</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">9-20-66</span> <span style="font-size: 1.2em;">4<sup>40</sup> P.M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">42 SINAI HOSP.</span>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MD.</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span> <span style="font-size: 1.2em;">15-11</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">3708 COLUMBUS DR.</span>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARRIED</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">JANUARY 1903</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">63</span>	If Under 1 Yr. Months: <span style="font-size: 1.2em;">—</span> Days: <span style="font-size: 1.2em;">—</span> Hours: <span style="font-size: 1.2em;">—</span> Min. <span style="font-size: 1.2em;">—</span> If Under 24 Hrs. Min. <span style="font-size: 1.2em;">—</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">WEIGH MASTER</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">H. KLAFF &amp; CO.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">WILNIECOWICZ POLAND</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">BENJAMIN SAX</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">ESTHER</span> <span style="font-size: 1.2em;">?</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span> <span style="font-size: 1.2em;">?</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">UNKNOWN</span>		17. INFORMANT <span style="font-size: 1.2em;">MRS. BETTY SAX</span> ADDRESS <span style="font-size: 1.2em;">3708 COLUMBUS DRIVE</span>	
18. <span style="font-size: 1.2em;">199-2-1</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <span style="font-size: 1.2em;">RESP. + CARDIAC ARREST</span> DUE TO (B) <span style="font-size: 1.2em;">HEPATIC COMA</span> DUE TO (C) <span style="font-size: 1.2em;">METASTATIC CA.</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">0</span> <span style="font-size: 1.2em;">44 hrs.</span> <span style="font-size: 1.2em;">9 MOS.</span>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="font-size: 1.2em;">—</span>					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span> <span style="font-size: 1.2em;">—</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">—</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">—</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <span style="font-size: 1.2em;">NO</span>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">—</span>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <span style="font-size: 1.2em;">—</span>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <span style="font-size: 1.2em;">—</span>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <span style="font-size: 1.2em;">—</span>	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <span style="font-size: 1.2em;">9-16-66</span> 19 <span style="font-size: 1.2em;">9-20</span> 19 <span style="font-size: 1.2em;">66</span> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <span style="font-size: 1.2em;">9-20</span> 19 <span style="font-size: 1.2em;">66</span> and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Alvin Schachter</span> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <span style="font-size: 1.2em;">9-20-66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">ALVIN SCHACHTER</span>		23D. ADDRESS <span style="font-size: 1.2em;">SINAI HOSP.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>	24B. DATE <span style="font-size: 1.2em;">9/21/66</span>	24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">BETH ISAAC ADATH ISRAEL</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">SEP 22 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farberman</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS. INC.</span> ADDRESS <span style="font-size: 1.2em;">6010 REISTERSTOWN</span>	

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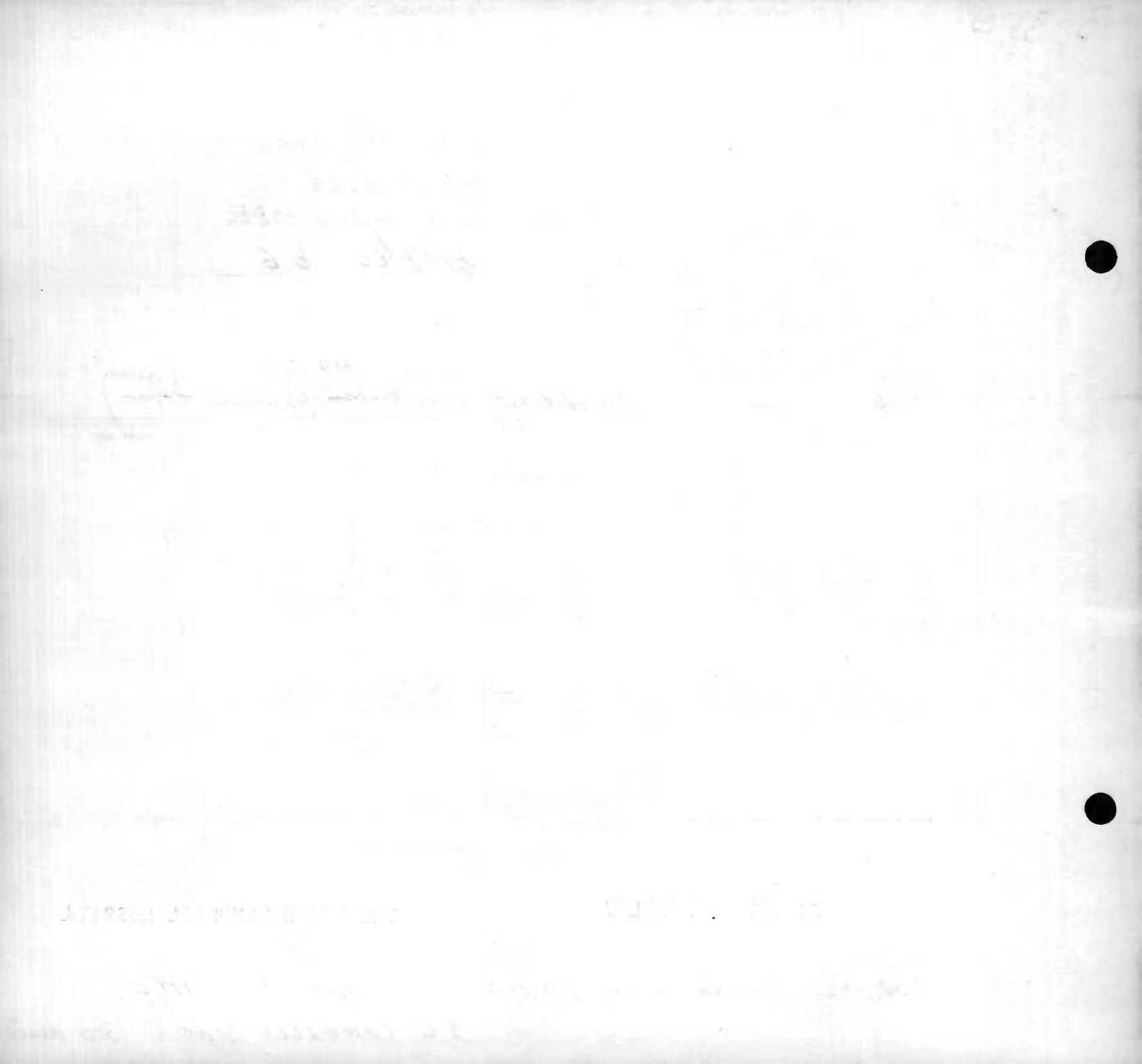




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

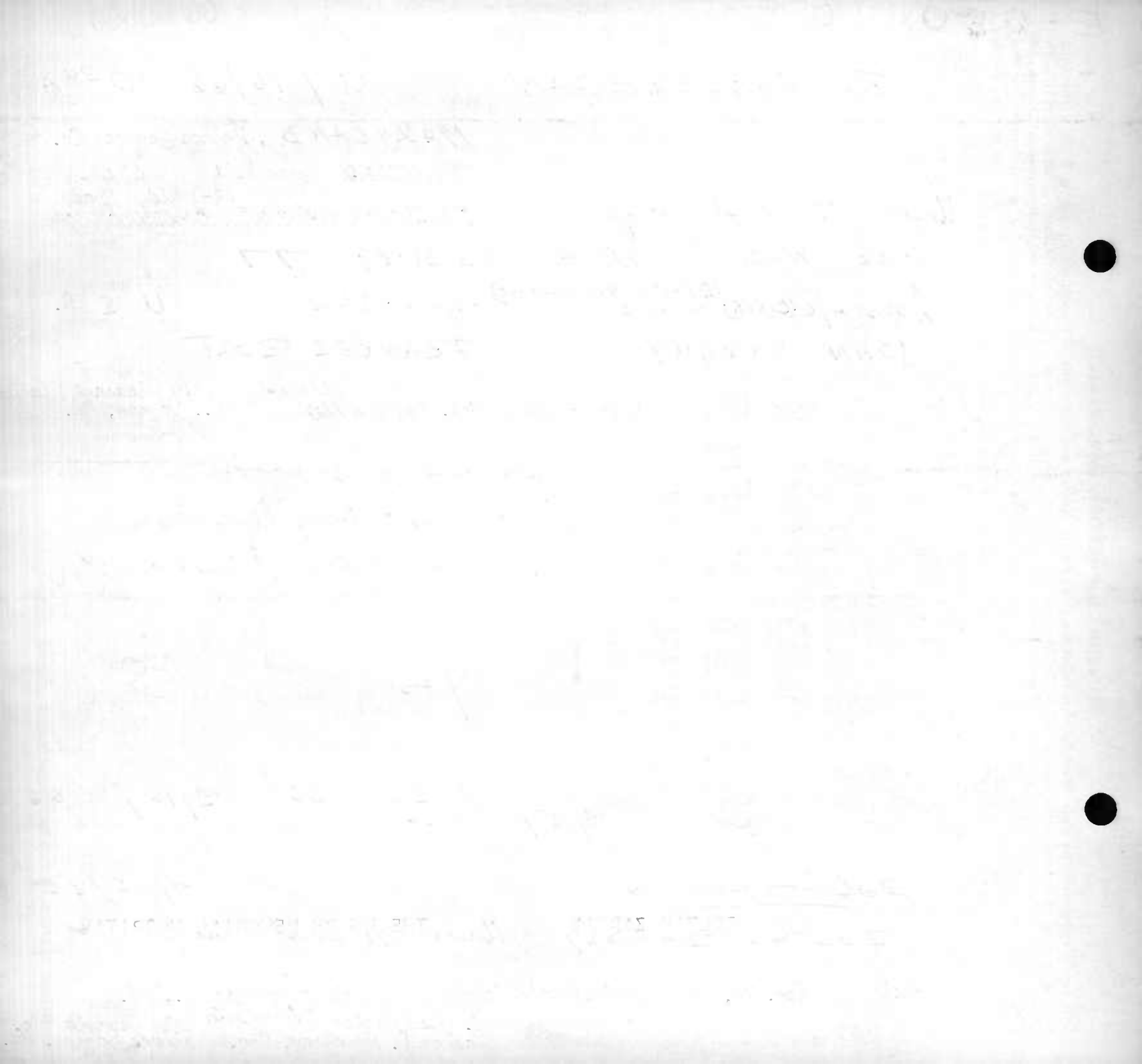
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 86 09589	
BIRTH NO. 66 09589				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>BUTTON ULRICH WILLIAM</b>			2. DATE AND HOUR OF DEATH <b>21 SEPT 66 16.00 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSP.</b> (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>908 - MACE AVE</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>2/14/00</b>	9. AGE (In years lost birthday) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSPECTOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>COUNTY GOV. LIQUOR BOARD</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>BUTTON, FRANK</b>			14. MOTHER'S MAIDEN NAME <b>WALK NOLLER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-144627</b>	17. INFORMANT ADDRESS <b>Mary Button (same as above)</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>327.1 I</b> <b>CAUSE OF DEATH</b> (A) <b>Cor pulmonale - chronic</b> DUE TO (B) <b>Emphysema</b> DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b>year</b>					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Secondary polycythemia</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>1</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/14/66</b> 19 to <b>9/21/66</b> 19, that (I) (we) lost saw the deceased alive on <b>9/21/66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Sidney E. Kirkley</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>21 Sept 66</b>	
23C. PHYSICIAN'S NAME (Type) <b>SIDNEY E. KIRKLEY</b>			23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b> M.D. <b>UNION MEM. HOSP.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>9/26/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>OAK LAWN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>J. G. CONNELLY SONS 300 MACE</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 09590	
BIRTH NO. 66 09590		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>FLORENCE SEGAN</b>		2. DATE AND HOUR OF DEATH <b>9 / 16 / 66 030 A M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hosp.</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND, Prince Georges Co.</b>		B. COUNTY	
C. CITY OR TOWN <b>Greenbelt</b>		(If outside city limits, write RURAL and give township)		D. STREET ADDRESS <b>69-D Ridge Road</b>		(If rural, give location)	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>03-31-89</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife (CLERK)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>DEPT. OF AGRICULTURE own home</b>		11. BIRTHPLACE (State or foreign country) <b>ARKANSAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN SURGUY</b>				14. MOTHER'S MAIDEN NAME <b>FRANCES BOST</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-56-6200</b>		17. INFORMANT <b>Mrs. Raymond Lijewski</b>		ADDRESS <b>8319 Pleasant Plains Rd., Towson, Md.</b>	
18. <b>332X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Cerebral Infarction</b> DUE TO (B) <b>Vertebral artery thrombosis</b> DUE TO (C) <b>Cerebral arteriosclerosis</b>			
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/22/1966</b> to <b>9/16/1966</b> , that (I) (we) lost saw the deceased alive on <b>9/15/1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Zoltan Zarday</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/16/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>ZOLTAN ZARDAY</b>				23D. ADDRESS <b>Union Memorial Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Sep. 20, 1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Fort Lincoln Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Prince Georges Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>C. Glen Carter</b>		25C. FUNERAL DIRECTOR <b>Warner E. Humphrey, Inc.</b>		ADDRESS <b>8434 Georgia Ave. Silver Spring, Md.</b>	



66 09591

BALTIMORE CITY HEALTH DEPARTMENT

66 09591

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LOUIS

KOLKER

2. DATE AND HOUR PRONOUNCED DEAD

September 14, 1966 4:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Union Memorial

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2745 Huntingdon Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Grocer

10B. KIND OF BUSINESS OR INDUSTRY

Proprietor

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Samuel Kolker

14. MOTHER'S MAIDEN NAME

Fannie

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

Mrs. Belle Kolker, 2745 Huntingdon Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 14, 1966

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9/18/66

23C. NAME of CEMETERY or CREMATORY

Hebrew Young Men

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 22 1966

Robert E. Springate

Sol Levinson &amp; Bros. Inc. 6010 Reisterstown

MAILED  
OFFICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09592		BALTIMORE CITY HEALTH DEPT.		CERTIFICATE OF DEATH		Registered No. 66 09592	
1. NAME OF DECEASED (Type or Print) CLARA B. SHARPE				2. DATE AND HOUR OF DEATH 9-19-66 5:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 333				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE NORTH CAROLINA B. COUNTY V-30 C. CITY OR TOWN (If outside city limits, write RURAL and give township) STATESVILLE D. STREET ADDRESS (If rural, give location) Rt # 1			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-3-19	9. AGE (In years last birthday) 47	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Iredell County, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME TOM ADAMS				14. MOTHER'S MAIDEN NAME <del>BLACKIE-DASK</del> Rosa B. Tomlin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 193.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Epidemiologist of 4th District</i> DUE TO (B) <i>operative removal of tumor</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 9/14		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Tumor of 4th Vent.</i>		20A. AUTOPSY? (Yes or No) ? NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/11/66 to 9/19/66, that (I) (we) last saw the deceased alive on 5:15 9/19/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>W. Smithwick</i> W. SMITHWICK				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/19	
23C. PHYSICIAN'S NAME (Type) W. SMITHWICK				23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-25-66		24C. NAME OF CEMETERY or CREMATORY Belmont		24D. LOCATION (City, town, or county) (State) Statesville, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1966		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS Rutledge & Bigham, Statesville, N.C.			





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09593		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 09593	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>ROSS, EVA M.</b>			2. DATE AND HOUR OF DEATH <b>9/21/1966 5:34 PM M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>46 Lutheran Hospital of Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>16-07</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>8820 Riggs Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>6-4-1892</b>	9. AGE (In years last birthday) <b>74</b>	10. If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Put Family</b>		11. BIRTHPLACE (State or foreign country) <b>BALCO MD</b>	
13. FATHER'S NAME <b>ALFRED ROSS</b>		14. MOTHER'S MAIDEN NAME <b>MARY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-46-3228</b>		17. INFORMANT <b>William Ross Jr 8021 Gordon St</b>	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO <b>Cerebral Hemorrhage</b> (B) DUE TO <b>Hypertension</b> (C) _____		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>at</del> (this hospital) attended the deceased from <b>9/18/1966</b> to <b>9/21/1966</b> , that <del>at</del> (we) last saw the deceased alive on <b>9/21/1966</b> and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>at</del> (We) (did) <del>not</del> view the body after death.					
23A. SIGNATURE <b>I. R. Rajae</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Iraj Rajae</b>		23D. ADDRESS <b>Lutheran Hospital</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burned</b>		24B. DATE <b>9/26/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Auburn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Marjorie A. Hays</b>			
ADDRESS <b>638 N. Green St</b>					

47

66 09594

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09594

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

John James, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

9/18/66 6:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3413 O'Donnell St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

11-26-1943

9. AGE (In years  
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Floor MAN

10B. KIND OF BUSINESS OR INDUSTRY

Glenhara Ltd

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John E. Sr

14. MOTHER'S MAIDEN NAME

Gertrude Addicks Potomac

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes 7-25-63 to 12-18-63

16. SOCIAL  
SECURITY NO.

214-42-8352

17. INFORMANT

Mrs. Patricia James 3413 O'Donnell St.

ADDRESS

18.

E976X1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Gunshot wound of head

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

factory

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

1414 Key Hwy.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
9 18 66 ?

21E. INJURY OCCURRED

WHILE AT  
WORK

[X]

NOT WHILE  
AT WORK

[ ]

21F. HOW DID INJURY OCCUR?

shot self

22.

I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion  
resulted from: Natural causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED

9/19/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9-22-66

23C. NAME of CEMETERY or CREMATORY

Balto Nat. Cem.

23D. LOCATION

Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 22 1966

24B. NAME OF REGISTRAR

Robert E. Feltner

24C. FUNERAL DIRECTOR

The Small. Hoffmann

ADDRESS

3218 Hudson St.

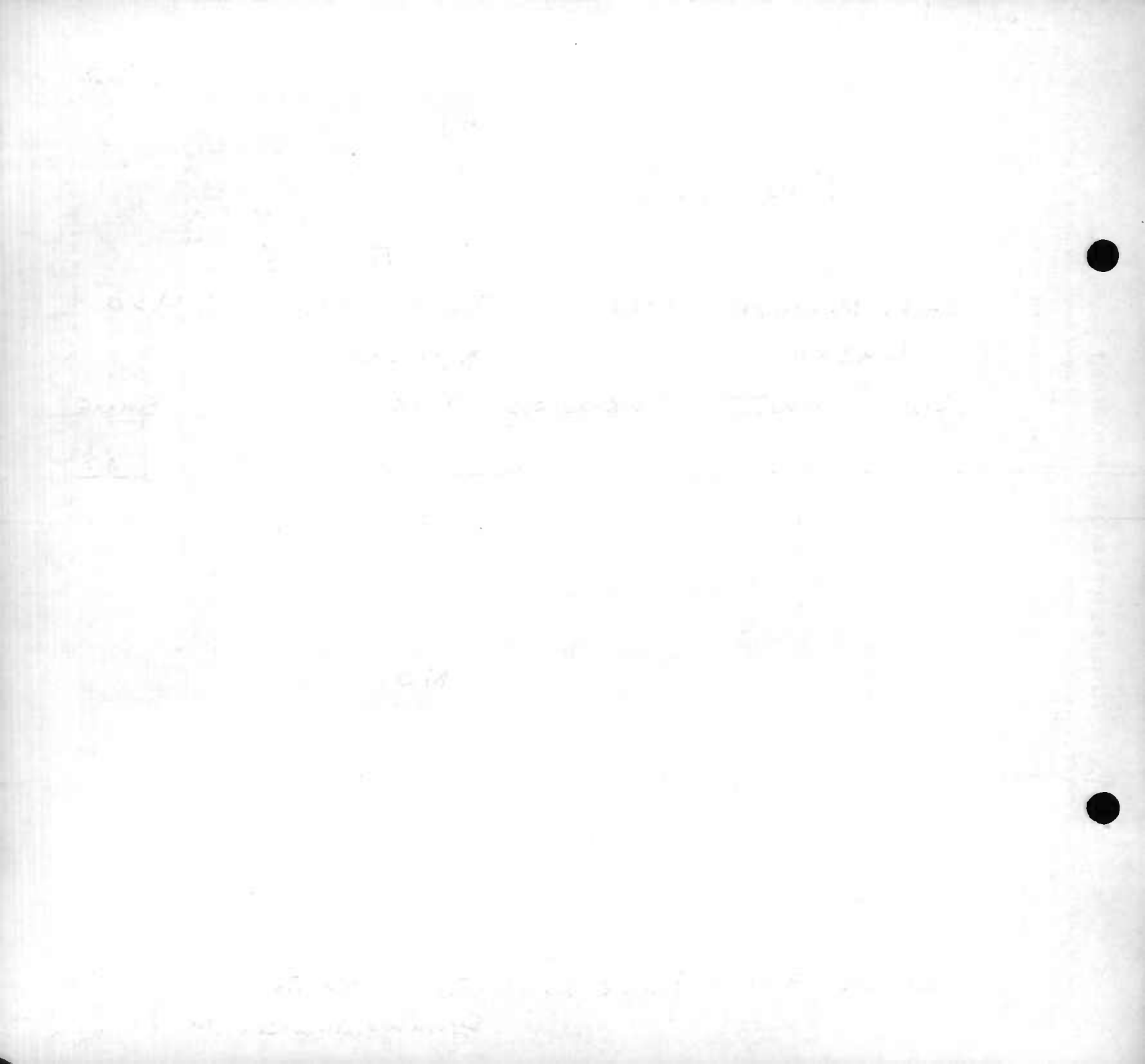
WALLEY POND

WALLEY POND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09595	
BIRTH NO. 66 09595		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>SACKS ISRAEL</b>		2. DATE AND HOUR OF DEATH <b>9/20/66 3:45 PM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>27-20</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSP</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>3309 LUDGATE RD</b>			
5. SEX <b>♂ M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>9/27/19</b>	9. AGE (In years last birthday) <b>46</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES MANAGER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>FOOD</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO, MD</b>	
13. FATHER'S NAME <b>LAZER</b>		14. MOTHER'S MAIDEN NAME <b>MIRIAM</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>216-03-2332</b>		17. INFORMANT <b>WIFE</b>	
18. <b>3-78X1</b>		CAUSE OF DEATH		ADDRESS <b>SAME</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Myocardial Infarct</b> DUE TO		<b>#2</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>G.I. Hemorrhage</b> DUE TO		<b>7</b>	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/19</b> 19 <b>66</b> to <b>9/20</b> 19 <b>66</b> and that (I) (we) last saw the deceased alive on <b>9/20</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I) (We) (did) (did not) view the body after death.</b>					
23A. SIGNATURE <b>S. Gordon</b>				23B. DATE SIGNED <b>9/20</b>	
23C. PHYSICIAN'S NAME (Type) <b>S. Gordon</b>		23D. ADDRESS <b>SINAI HOSP</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/22/66</b>		24C. NAME of CEMETERY or CREMATORY <b>General War Vets</b>	
24D. LOCATION <b>Balto</b>		24E. STATE <b>MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Sylvan S. Lewis &amp; Son, INC</b>	
				ADDRESS <b>3344 Olympic Ave</b>	



## CERTIFICATE OF DEATH

Registered No. 66 09596

BIRTH NO.

66 09596

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ABROMOWITZ, MIRIAM

2. DATE AND HOUR OF DEATH

9/20-1966

9:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)31 4940 EASTERN AVENUE  
BALTIMORE, MARYLAND #21224  
Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

BALT. Md. MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALT. Baltimore

D. STREET ADDRESS (If rural, give location)

3706 W. ROGERS AVE #21215

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

2-19-05

9. AGE (In years  
last birthday)

61

11. Under 1 Yr.  
Months Days12. Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

typing + sales

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT BALTIMORE CITY HOSPITALS ADDRESS

RECORDS: 4940 EASTERN AVE BALTO., MD. #24

18. 1338

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenio, etc. It means the disease,  
injury or complication which caused death.)(A) CARCINOMA of colon  
DUE TO METASTATIC

? 2 1/2 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/23/66 19 to 9/20 19 66.  
that (I) (we) lost saw the deceased alive on 9-20 19 66 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard D. Maffezzoni

M.D.

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

9-20-66

23C. PHYSICIAN'S  
NAME (Type)

MAFFEZZONI, RICHARD

M.D.

23D. ADDRESS

4940 EASTERN AVE. BALTO., MD. #21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

9/22/66

24C. NAME OF CEMETERY or CREMATORY

Mt Carmel

24D. LOCATION

(City, town, or county)

Baltimore

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

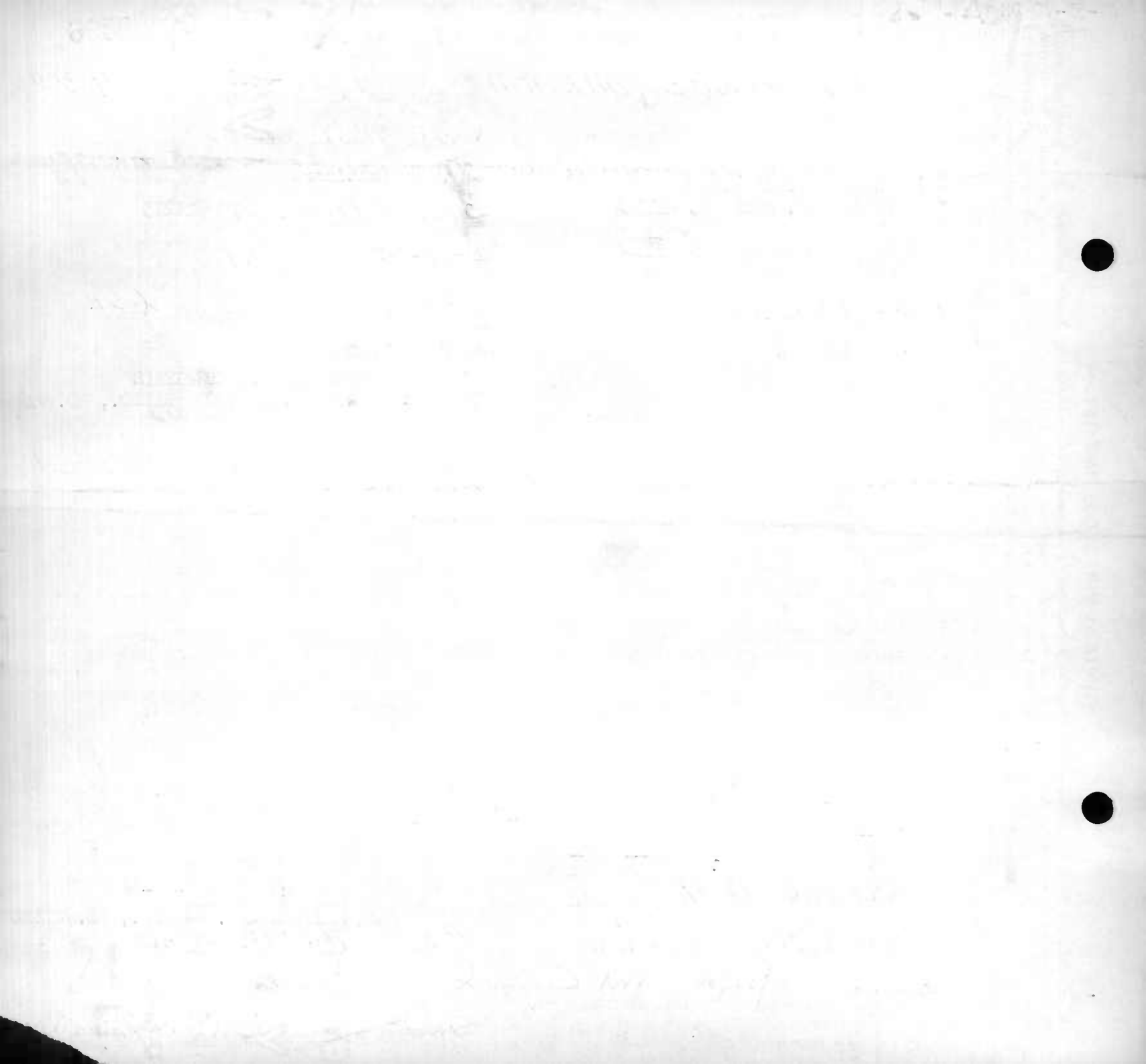
25C. FUNERAL DIRECTOR

ADDRESS

Sybil S. Lewis &amp; Son 331 N. ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09597</u>	
BIRTH NO. <u>66 09597</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>HARRY ROSEN BERGER</u>		2. DATE AND HOUR OF DEATH <u>SEPT. 21, 1966</u> <u>11:35 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>CHURCH HOME AND HOSPITAL</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Church Home and Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>26-10</u> D. STREET ADDRESS (If rural, give location) <u>3211 E. BALTIMORE ST.</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>7-27-1881</u>	9. AGE (In years lost birthday) <u>85</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLTIC, LAUNDRY</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>HENRY ROSENBERGER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZA BETH VOELKER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>48-01-3288</u>		17. INFORMANT ADDRESS <u>Mrs. Gertrude Laupus 6832 Broening Highway</u>	
18. <u>593X141621</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Renal Failure</u>		CAUSE OF DEATH (A) <u>Uremia</u> DUE TO (B) <u>Chronic Renal Failure</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>few days</u> <u>unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Low. Bronchopneumonia @</u>					
19A. DATE OF OPERATION <u>2 NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>SEPT 3</u> 19 <u>66</u> to <u>SEPT 21</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>SEPT 21</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Rodilio M. Lim</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-21-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>RODELIO M. LIM</u>		23D. ADDRESS <u>CHURCH HOME &amp; HOSP.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9/24/1966</u>	24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1966</u>		25B. NAME OF REGISTRAR <u>John A. Moran Inc.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>3000 E. Baltimore St.</u>	

Urania  
Chamaea (leafy)

for botanical specimens

Robert M. Linn  
Grand Hotel & Regency

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO.	
66 09598		66 09598		66 09598	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>RENNIE, WILLIAM A.</b>			2. DATE AND HOUR OF DEATH <b>September 22, 1966 3:55 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Maryland 21218</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write BLUR and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>4660 York Road</b>		
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4/26/97</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHIPYARD</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
13. FATHER'S NAME <b>JOHN RENNIE</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 8/26/17 to 5/16/19</b>			16. SOCIAL SECURITY NO. <b>215 09 8559</b>		17. INFORMANT ADDRESS <b>Veterans Hospital Records Baltimore, Maryland 21218</b>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ARTERIOSCLEROTIC HEART DISEASE WITH MYOCARDIAL INFARCTION</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>BULLOUS, OBSTRUCTIVE EMPHYSEMA, SEVERE</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 7</b> 19 <b>66</b> to <b>September 22</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>September 22</b> 19 <b>66</b> and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>D. Edwards Smith, M. D.</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>9/22/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>D. Edwards Smith, MD</b>		23D. ADDRESS <b>Veterans Administration Hospital Baltimore, Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9/26/1966</b>	24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>D. Edwards Smith, MD</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John A. Moran Inc. 3000 E. Baltimore St.</b>	

REPORT OF THE  
COMMISSIONER OF THE  
LAND OFFICE  
TO THE  
LEGISLATIVE COUNCIL  
ON THE  
LANDS BELONGING TO THE  
CROWN

IN THE  
YEAR 1891

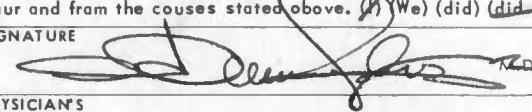
1891

1891

PRINTED BY THE  
GOVERNMENT PRINTER

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09599		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09599	
1. NAME OF DECEASED (Type or Print) <b>Johnson MABEL O.</b>			2. DATE AND HOUR OF DEATH <b>9/19/66 7:00 p.m.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secours.</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto 17 15-02</b>		
D. STREET ADDRESS (If rural, give location) <b>1724 Mc Kean Ave</b>					
5. SEX <b>F</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>10-23-93</b>	9. AGE (In years lost birthday) <b>72</b>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Henry Overton</b>			14. MOTHER'S MAIDEN NAME <b>GACE Britton</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-093589A</b>		17. INFORMANT ADDRESS <b>Vernice Bias 2568 Cecil Ave</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>466X I</b>			CAUSE OF DEATH (A) <b>Emboly, main pulmonary artery.</b> (B) <b>Thrombosis in deep leg vein with embolization</b> (C)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>yes</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>8-25 1966</b> to <b>9-19 1966</b> , that (we) last saw the deceased alive on <b>9-19 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <b>9-19-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>A. MENDOUZA</b>		23D. ADDRESS <b>BON SECOURS HOSP</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/23/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Urlington Shildy 1727 N. Mount St.</b>	

End of the manuscript  
written  
transcribed in 1870 by  
a different hand

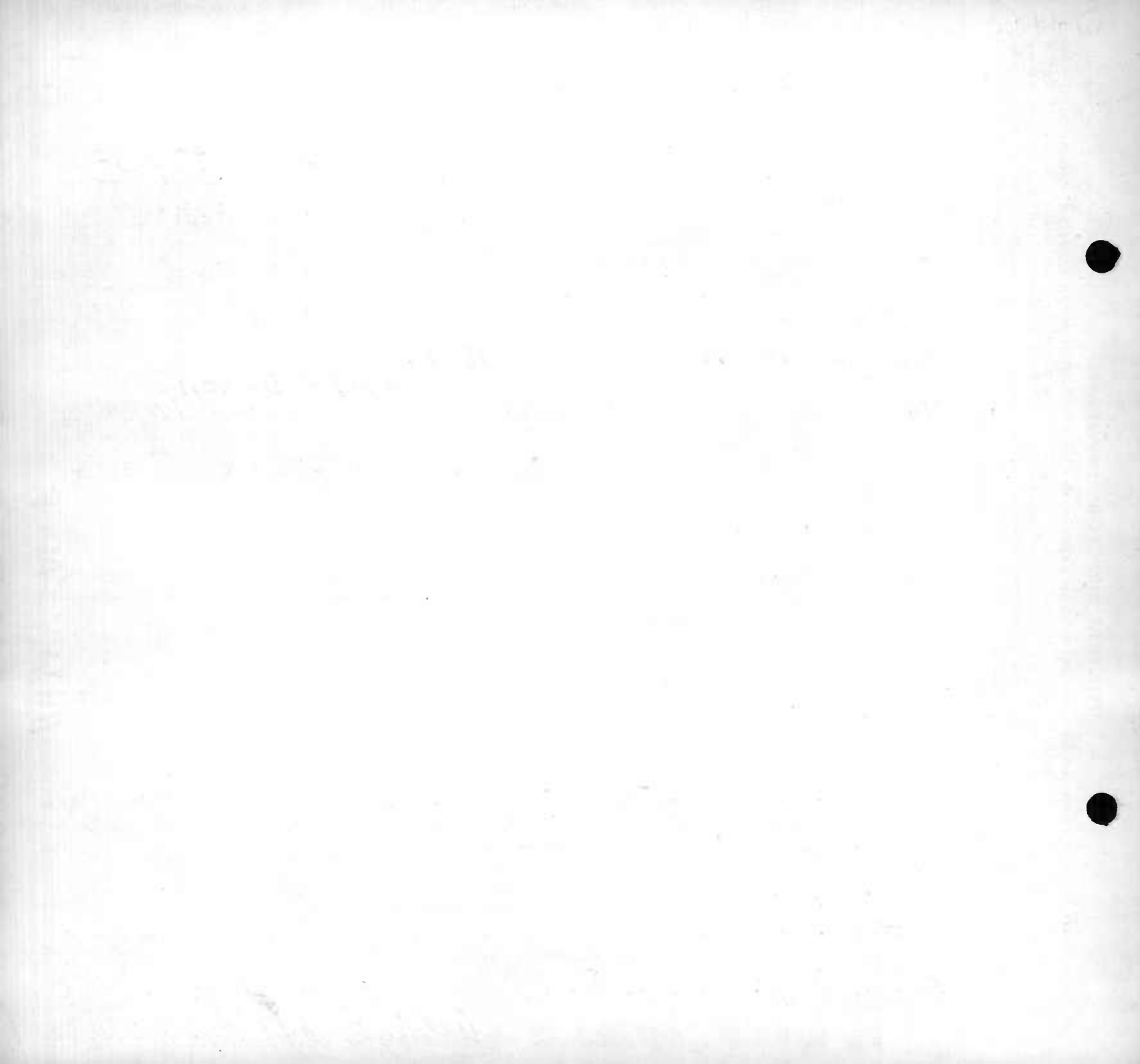
Yes

Yes

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09600</u>
BIRTH NO. <u>66 09600</u>		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>INA W. DOWELL</u>		2. DATE AND HOUR OF DEATH <u>9-20-66</u>   <u>11:00 A.M.</u>
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <u>MONTEBELLO STATE HOSPITAL</u> <u>91</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1707 WARWICK AVE</u>		
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>7-14-16</u>	9. AGE (In years last birthday) <u>50</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. CAROLINA</u>
13. FATHER'S NAME <u>GOLDAR McNAIR</u>		14. MOTHER'S MAIDEN NAME <u>RUBY McCLOUD</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-22-2267</u>	17. INFORMANT <u>Earl F. Dowell</u> <u>HOSPITAL RECORD</u>	
18. <u>170X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>CARCINOMA OF BREAST</u> DUE TO (B) _____ DUE TO (C) _____  INTERVAL BETWEEN ONSET AND DEATH <u>6 YEARS</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>6-16</u> 19 <u>66</u> to <u>9-20</u> 19 <u>66</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>9-20</u> 19 <u>66</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Irving L. Cooperstein</u>		M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-20-66</u>
23C. PHYSICIAN'S NAME (Type) <u>Irving L. COOPERSTEIN</u>		23D. ADDRESS M.D. <u>MONTEBELLO STATE HOSPITAL, BALTO. - MD.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>	24B. DATE <u>9/23/66</u>	24C. NAME of CEMETERY or CREMATORY <u>MC LEAD</u>		24D. LOCATION (City, town, or county) (State) <u>Laurinburg N.C.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1966</u>		25B. NAME OF REGISTRAR <u>Earl F. Dowell</u>		25C. FUNERAL DIRECTOR <u>Arlington Phillips</u> ADDRESS <u>1727 N. Mount St.</u>





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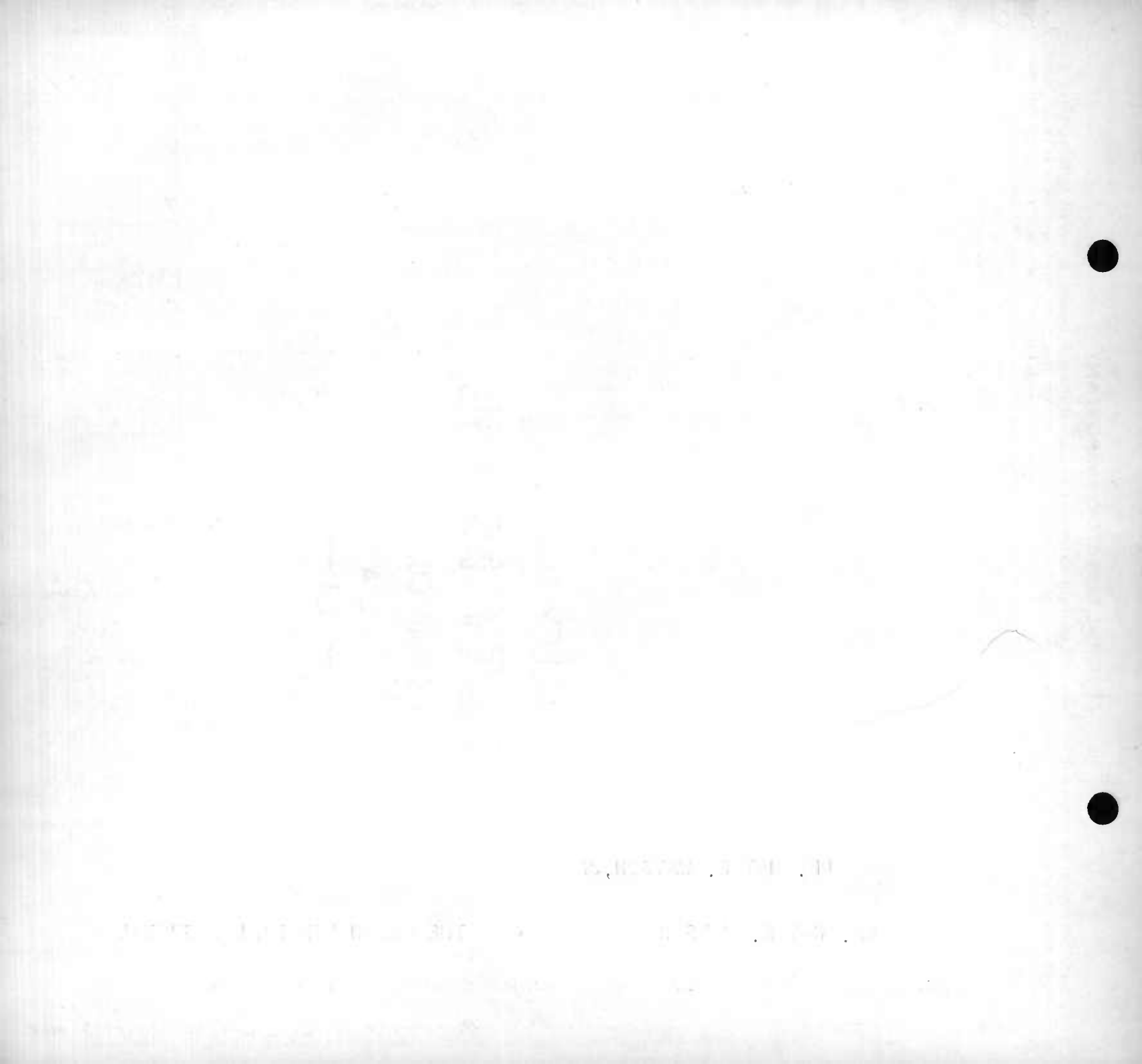
BIRTH NO. <b>66 09601</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>66 09601</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MR. Oliver, Albertus</b>		2. DATE AND HOUR OF DEATH <b>1:30 a.m. 9/18/66</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hosp. in Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		<b>28-03</b>	
D. STREET ADDRESS (If rural, give location) <b>4133 Forest Pr. Ave.</b>		5. SEX <b>Male</b>		6. RACE <b>C.</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>5/9/15</b>		9. AGE (In years lost birthday) <b>51</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Repairman</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
13. FATHER'S NAME <b>Moses Oliver</b>		14. MOTHER'S MAIDEN NAME <b>Susan Oliver</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Daughter</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>C.V.A.</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10:45 a.m. 9/18/66</b> to <b>1:30 a.m. 9/18/66</b> , that (I) (we) last saw the deceased alive on <b>1:15 a.m. 9/18/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. Kim</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>WON JA KIM</b>		23D. ADDRESS <b>Lutheran Hosp. of Baltimore</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/22/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Carver Mem. Ph. Laurel</b>	
24D. LOCATION <b>Md.</b>		25A. DATE REC'D BY HEALTH/DEPT.		25B. NAME OF REGISTRAR <b>Arsling Phillips</b>	
25C. FUNERAL DIRECTOR <b>1727 N. Meade St</b>		ADDRESS			



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BIRTH NO. 66 09602				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 09602	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>Louis Rice</u>		2. DATE AND HOUR OF DEATH <u>Sept. 19, 1966</u> <u>7:18 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>12-04</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>				D. STREET ADDRESS (If rural, give location) <u>2004 Barclay Street</u>					
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years lost birthday) <u>67</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Workman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas Rice</u>				14. MOTHER'S MAIDEN NAME <u>India Unknown Edmonds</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Emma Rice</u>		ADDRESS <u>Same</u>			
18. <u>334X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>pneumonia, Rt. middle</u> DUE TO (B) <u>Encephalomalacia, cerebellum</u> DUE TO (C) <u>HF</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Sept 15</u> 19 <u>66</u> to <u>Sept 19</u> 19 <u>66</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>Sept. 19</u> 19 <u>66</u> and that (in my) ( <del>last</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) (did) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <u>DR. NAT E. WATSON, JR.</u> <u>Nat E. Watson Jr.</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/19/66</u>			
23C. PHYSICIAN'S NAME (Type) <u>DR. NAT E. WATSON</u>				23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>SEPT. 24, 66</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. CALVARY CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>A.A. Co. Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Marshall W. Jones, Jr. 1735 HANFORD AVE.</u>					



# FUNERAL DIRECTOR: IMPORTANT

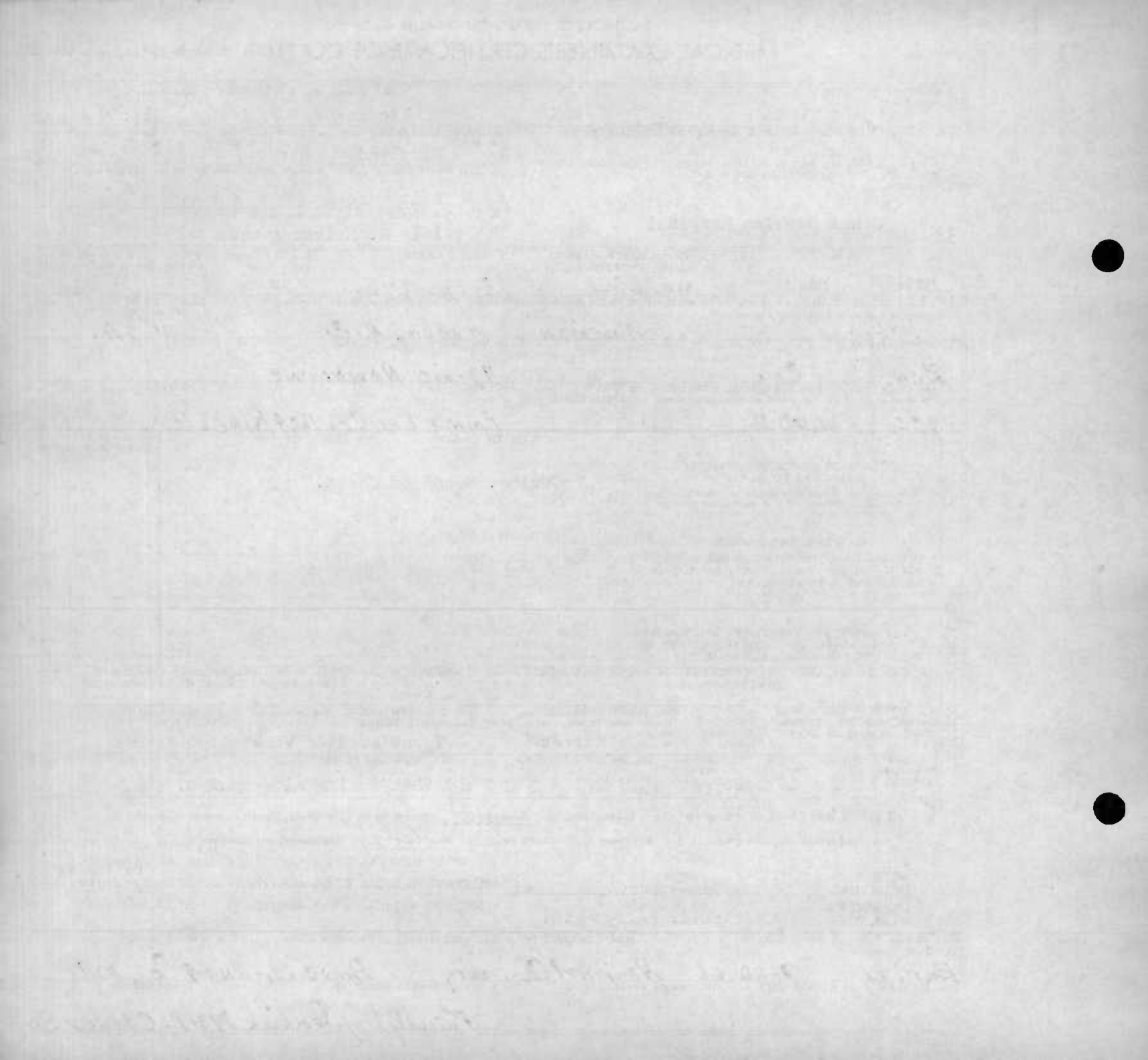
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BIRTH NO. 66 09603		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09603	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>JOSHUA CARRINGTON</u>		2. DATE AND HOUR OF DEATH <u>9/19/66</u> <u>1300</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) <u>JOHNS HOPKINS HOSPITAL</u>		A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>1509 N Decker Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED NEVER MARRIED <u>Married</u>	8. DATE OF BIRTH <u>3-3-03</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joshua Carrington</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Brooks</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-2868</u>		17. INFORMANT <u>Loretta Carrington</u> ADDRESS <u>1509 N. Decker Ave</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>MYOCARDIAL INFARCTION</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>1 9/14/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>aneurysm of aorta</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/11</u> 19 <u>66</u> to <u>9/19</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. Silk</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/19/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>MARK SILK</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSP.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>9-23-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Harmony Cemetery</u>	
24D. LOCATION (City, town, or County) (State) <u>Harmony, Virginia</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1966</u>			
25B. NAME OF REGISTRAR <u>Randolph Collick</u>		25C. FUNERAL DIRECTOR ADDRESS <u>2431 E. Oliver St.</u>			



VS 151-REV. 1/1/65

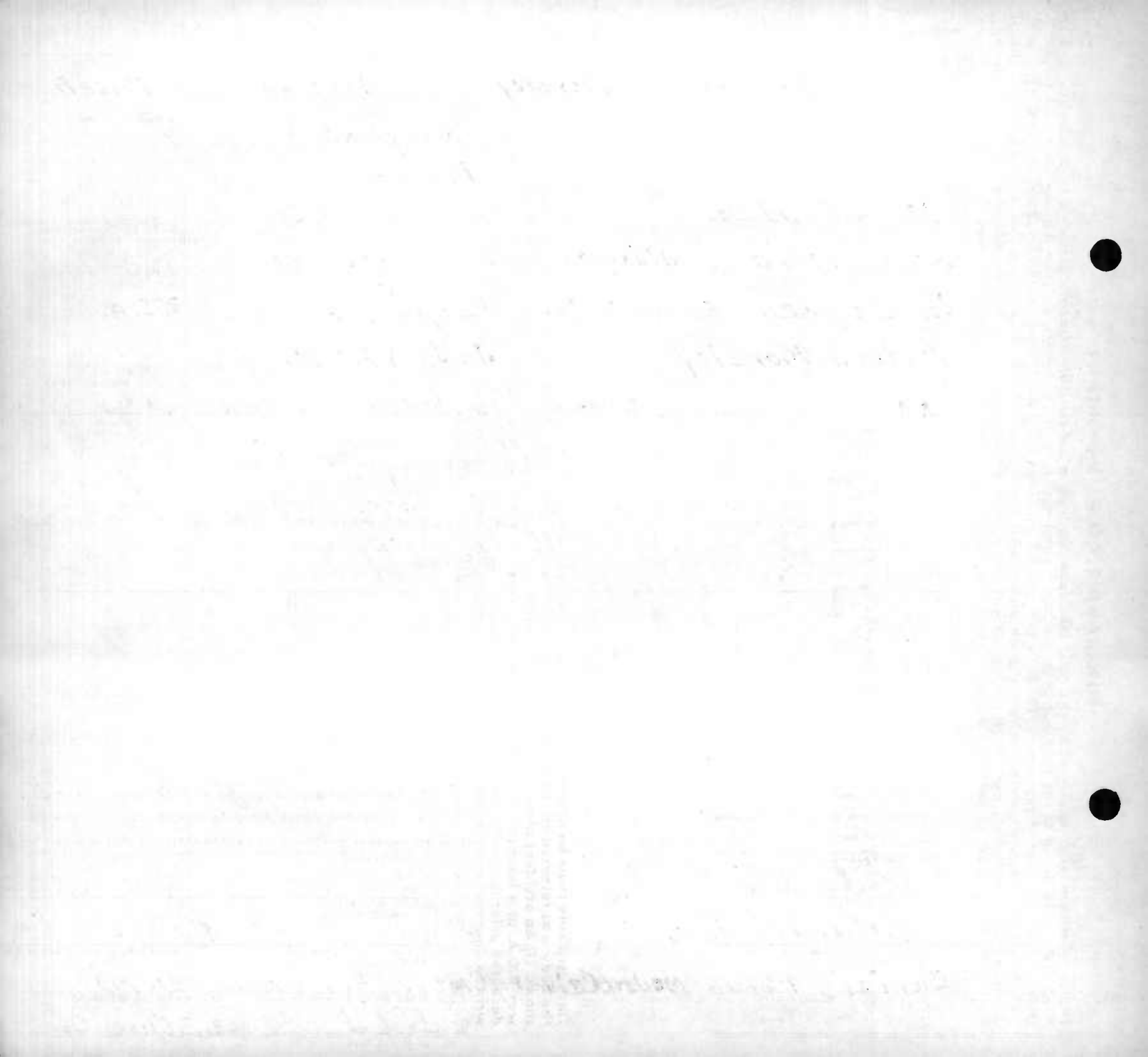






This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

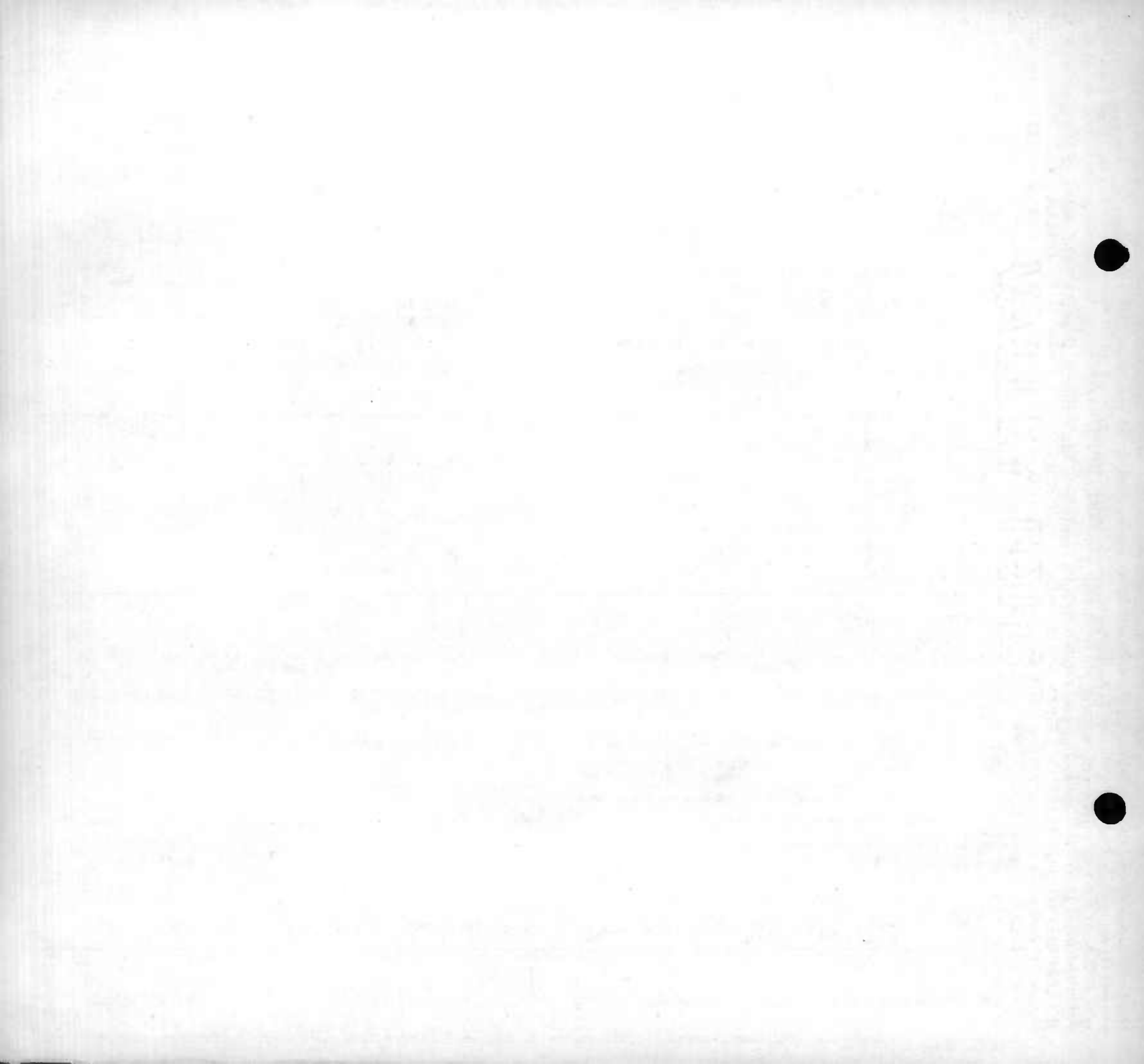
BIRTH NO. 66 09605				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09605			
M.E. CASE NO.				CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>Emmett Marsley</b>				2. DATE AND HOUR OF DEATH <b>9-19-66 12:00 P. M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>8-07</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1215 N. Bond St.</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>					
				D. STREET ADDRESS (If rural, give location) <b>1215 N. Bond St.</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>3-1885</b>		9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steamship Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Pamplin, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Andrew Marsley</b>				14. MOTHER'S MAIDEN NAME <b>Julia Wheeler</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-03-2067</b>		17. INFORMANT <b>Mrs Della Gordon</b>		ADDRESS <b>1215 N. Bond St.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Coronary Occlusion</b> DUE TO (B) <b>Hypertensive Cardiovascular Disease</b> DUE TO (C) <b>Senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Day</b>			
				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
				19A. DATE OF OPERATION <b>9-20-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>6-16-1966</b> to <b>9-19-1966</b> , that (I) (we) last saw the deceased alive on <b>9-17-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Richard H. Hunt</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9-20-66</b>			
23C. PHYSICIAN'S NAME (Type) <b>Richard H. Hunt</b>				23D. ADDRESS <b>1607 W. Mulberry St. Balto. Md.</b>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-22-66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary Ctry.</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Co. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>James E. Jones</b>		25C. FUNERAL DIRECTOR <b>Randolph Collick</b>					
				ADDRESS <b>2431 E. Oliver St.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

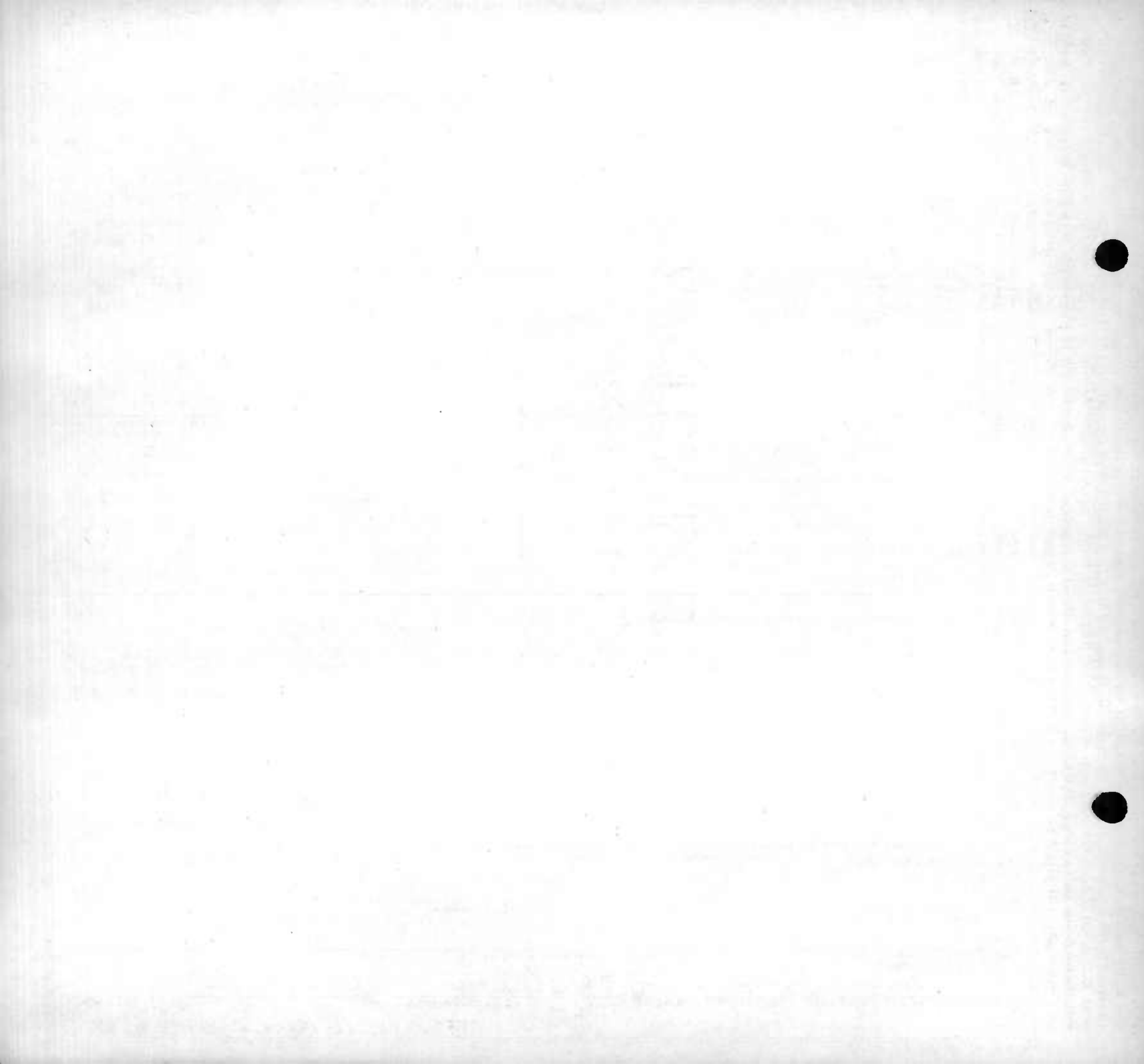
BIRTH NO. <b>66 09806</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09806</b>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>Jones, Jessie SEECOLA</b>			2. DATE AND HOUR OF DEATH <b>9-22-66 15 10 A M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hosp.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO. MD.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO. MD.</b> D. STREET ADDRESS (If rural, give location)		
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>3-18-1900</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baby Sitter</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
13. FATHER'S NAME <b>JAMES HATTISON</b>			14. MOTHER'S MAIDEN NAME <b>SARAH ALSON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORDS</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>332X17-260X</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			CAUSE OF DEATH (A) <b>Acute Coronary Artery Thrombosis</b> DUE TO (B) <b>Coronary ASCVD</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>CONGESTIVE HEART FAILURE</b> <b>DIABETES MELLITUS</b>					
19A. DATE OF OPERATION <b>9/22/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/22</b> to <b>9/22</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/22</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Irvin M. Sopher</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9/22/66</b>
23C. PHYSICIAN'S NAME (Type) <b>IRVIN M. SOPHER</b>			23D. ADDRESS <b>University Hosp. Balto. Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-26-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Brooklyn, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>Edna E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>	
				ADDRESS <b>661 W. Banne St</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 09607		CERTIFICATE OF DEATH		Registered No. 31-56-56	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Vaughn Gertrude, Estelle				2. DATE AND HOUR OF DEATH 9/21/66 3:30 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital		A. STATE Maryland		B. COUNTY 4-02		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 221 W. FREMONT	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12-11-82	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James A. Vaughn				14. MOTHER'S MAIDEN NAME SARA H. J. Montgomery					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Admissions Record			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) Myocardial infarction DUE TO (B) Atherosclerotic hypertension heart disease (C)				INTERVAL BETWEEN ONSET AND DEATH 3 hrs. unknown	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Drainage of subphrenic abscess.					
19A. DATE OF OPERATION 9/21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED subdiaphragmatic abscess		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 8/30 1966 to 9/21 1966, that (I) (we) last saw the deceased alive on 9/21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Fred R. Eilber M.D.		23B. DATE SIGNED 9/21/66			
23C. PHYSICIAN'S NAME (Type) Fred R. Eilber M.D.		23D. ADDRESS University Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-24-66		24C. NAME of CEMETERY or CREMATORY Bethel Cemetery		24D. LOCATION (City, town or county) (State) Cambridge, Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St			



## CERTIFICATE OF DEATH

BIRTH NO.

MED. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Ralph S. Marvel

2. DATE AND HOUR OF DEATH

21 Sept 1966 1 15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospital  
4940 Eastern Avenue, Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Balt. Md 53-00

D. STREET ADDRESS (If rural, give location)

Route #14 Box 640

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED, (Specify)

Married

8. DATE OF BIRTH

3/25/93

9. AGE (In years  
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.  
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Plumbing Contractor

10B. KIND OF BUSINESS OR INDUSTRY

GENERAL

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

ROBERT Nutter

Marvel

14. MOTHER'S MAIDEN NAME

Sally V. Ross

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

218-07-1039

17. INFORMANT

Records: BCH-4940 Eastern Avenue 21224

ADDRESS

18.

294X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A)  
DUE TO

Cardiac Arrest

30 min

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B)  
DUE TO

CVA

12 days

(C)

2° Polycythemia

?

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

probable Gram Neg. Sepsis

? 3 days

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH? YES21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from 9 Sept 19 66 to 21 Sept 19 66,  
that (H) (we) last saw the deceased alive on 21 Sept 19 66 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.

23A. SIGNATURE

D.A. Raine Jr.

M.D.

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

21 Sept 1966

23C. PHYSICIAN'S  
NAME (Type)

D.A. Raine Jr.

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

Sept 24 66

24C. NAME of CEMETERY or CREMATORY

Spring Hill

24D. LOCATION

Easton Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH/DEPT.

SEP 22 1966

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Ralph Clark

ADDRESS

Easton

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

High Mount

Baltimore City Hospital

W. W. W. W.

Western Mount  
Blowing Rock

21 Sept 1964

Longwood

21 Sept 1964

Monte #14

2/23/73

Longwood

2/1/73

Condon Mount

CVA

9. 1/2/73

Probable County. 2/23/73

21 Sept 1964

Q. Mount

21 Sept 1964

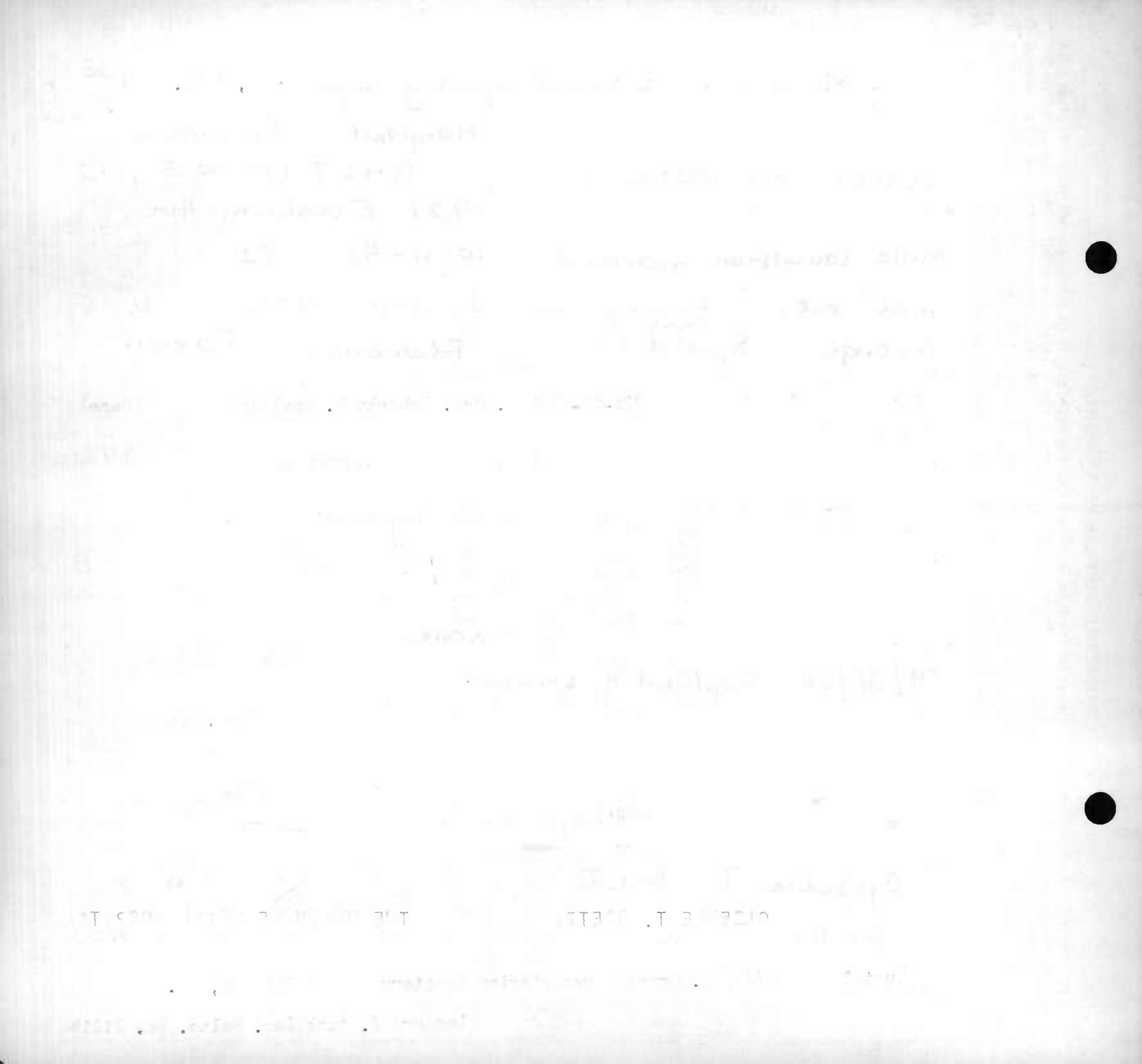
21 Sept 1964



# FUNERAL DIRECTOR: IMPORTANT

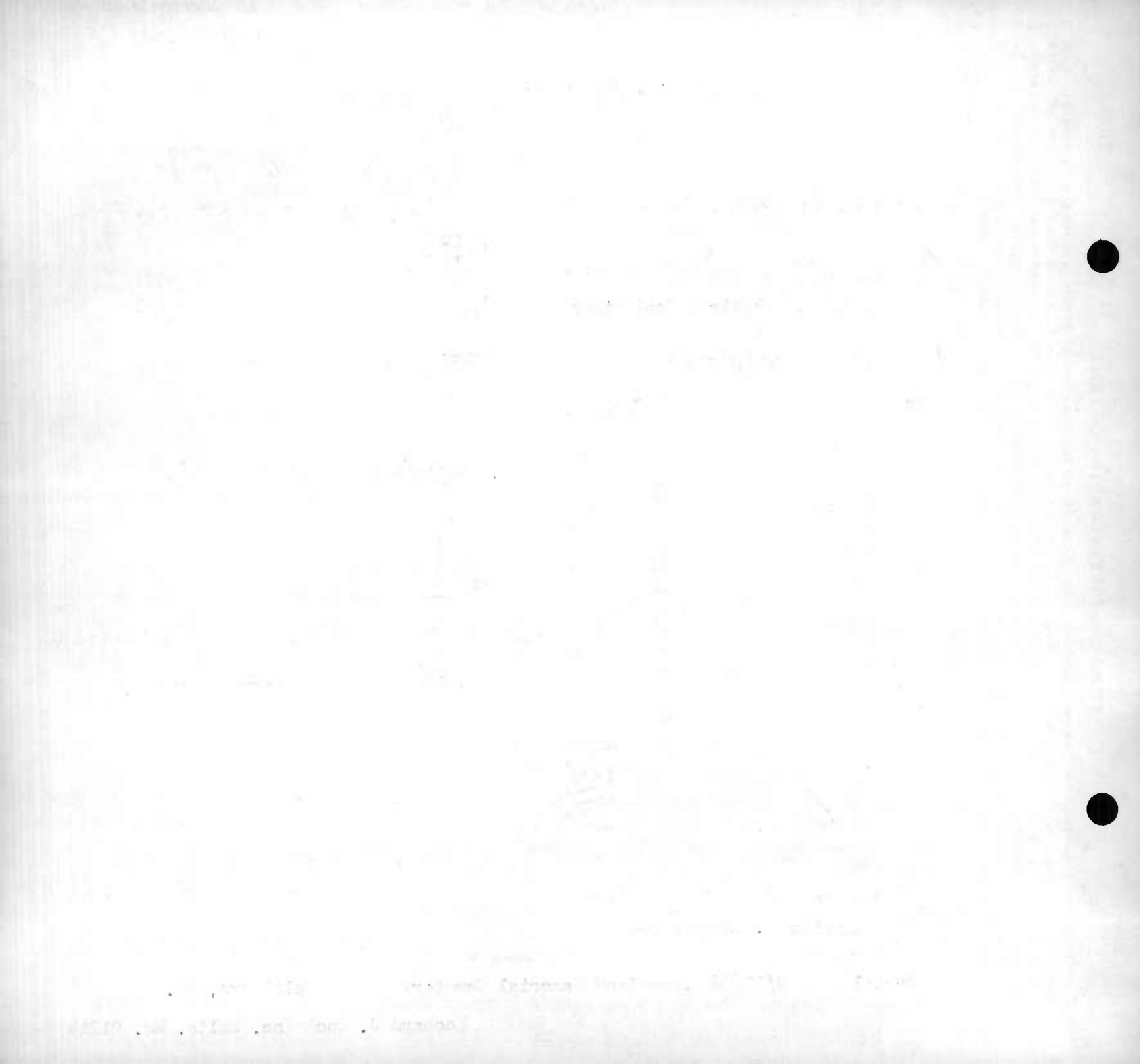
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09609	
BIRTH NO. 66 09609					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Mr. Robert Edward Spalding			2. DATE AND HOUR OF DEATH Sept 22, 1966. 120 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP			A. STATE Maryland B. COUNTY Baltimore		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 12		
44			D. STREET ADDRESS (If rural, give location) 921 Evesham Ave		
5. SEX male	6. RACE caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 10-31-93	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) real est.		10B. KIND OF BUSINESS OR INDUSTRY Rusel Behr Real Est.	11. BIRTHPLACE (State or foreign country) Boston, Mass.		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME George Spalding			14. MOTHER'S MAIDEN NAME Florence Faxon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. 321-07-9364	17. INFORMANT A. Mrs. Roberta B. Spalding		ADDRESS (Same)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none			CAUSE OF DEATH (A) Ruptured aortic aneurysm (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 24 hours B.W.
19A. DATE OF OPERATION 9/21/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured A. aneurysm		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from Sept 21 1966 to Sept 22 1966, that (we) last saw the deceased alive on 120 AM Sept 22 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Giselle T. Bretz M.D.				23B. DATE SIGNED 9.22.66	
23C. PHYSICIAN'S NAME (Type) Giselle T. BRETZ		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/24/66	24C. NAME OF CEMETERY or CREMATORY Govans Presbyterian Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE RECEIVED BY HEALTH DEPT. SEP 22 1966		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.		25C. FUNERAL DIRECTOR ADDRESS Balto. Md. 21214	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 09610</span>	
BIRTH NO. <span style="float: right;">66 09610</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>TURNER BRUMAGE</b>			2. DATE AND HOUR OF DEATH <b>9-22-66 6:45 AM</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>91 MONTEBELLO STATE HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>#6 27-34</b> D. STREET ADDRESS (If rural, give location) <b>5521 WALTHER AVE</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWER</b>	8. DATE OF BIRTH <b>1-29-84</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MINER Retired Coal Mines</b>			11. BIRTHPLACE (State or foreign country) <b>W. VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>PERRY BRUMAGE</b>			14. MOTHER'S MAIDEN NAME <b>Nancy CAMPBELL</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>235-126740</b>	17. INFORMANT ADDRESS <b>HOSPITAL RECORD</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>420.01 ARTERIOSCLEROTIC HEART DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>YRS.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>PULMONARY EMBOLUS 6 WEEKS</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>6-23 19 66</b> to <b>9-22 1966</b> , that <b>(H)</b> (we) last saw the deceased alive on <b>9-22 19 66</b> and that in <b>(M)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(H)</b> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Irving L. Cooperstein</b> M.D.			23B. DATE SIGNED <b>9-22-66</b>		23C. PHYSICIAN'S NAME (Type) <b>Irving L. Cooperstein</b> M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/23/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09611				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09611	
M.E. CASE NO.				CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>Lenoy Kirsch</b>				2. DATE AND HOUR OF DEATH <b>9-19-66</b> <b>4:16 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland # 21224</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				D. STREET ADDRESS (If rural, give location) <b>2823 FLEETWOOD AVE #14</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>4-17-1935</b>	9. AGE (In years last birthday) <b>31</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TRUCK DRIVER</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Kirsch</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Costello</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-09-7176</b>		17. INFORMANT <b>BCH: Records 4940 Eastern Ave. Baltimore, Md.</b>		ADDRESS # <b>21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH <b>Pneumonia</b> <b>Hip Fracture</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4d.</b> <b>11 wks</b>	
19A. DATE OF OPERATION <b>9-20-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>hip fracture</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home (former)</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>629 Dunbarton Ave</b>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>6 23 66 ?</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6-24-1966</b> to <b>9-19-66</b> 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>9-19</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William A. Emerson</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9-19-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>William A. Emerson</b>				23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave. Baltimore, Maryland # 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/23/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>PARKWOOD CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farnham</b>		25C. FUNERAL DIRECTOR <b>LEONARD J. RUCK, INC., BALTO., MD. 21214</b>		ADDRESS	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09612				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 66 09612	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Philip (Phillip) Di Venti</i>				2. DATE AND HOUR OF DEATH <i>September 22, 1966 12<sup>30</sup> P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY	
<i>Union Memorial Hospital</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>27-34</i>	
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>11/19/86</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CONTRACTOR</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>See 10A</i>		9. AGE (In years last birthday) <i>79 yrs.</i>		11. BIRTHPLACE (State or foreign country) <i>Italy</i>	
13. FATHER'S NAME <i>Michael Di Venti</i>				12. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>213-12-4224</i>		17. INFORMANT <i>Theresa Sodaro</i>	
18. <i>103.3</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) <i>pulmonary embolism</i>			
ANTECEDENT CAUSES				(B) <i>CA of sigmoid &amp; small bowel involvement</i>		<i>about 6 months</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <i>metastasis to lung, liver</i>		<i>4 K. min</i>	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>9/20/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CA of sigmoid colon</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>NA</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>NA</i>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>NA</i>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work <input type="checkbox"/> <i>NA</i> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>NA</i>			
22. I certify that (it) (this hospital) attended the deceased from <i>9/21/66</i> 19 to <i>9/22/66</i> 19, that (it) (we) last saw the deceased alive on <i>9/22/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (It) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Thomas H. Burrows</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9/22/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>THOMAS H. BURROWS</i>				23D. ADDRESS <i>90 UNION MEMORIAL HOSPITAL ITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>9-26-66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 22 1966</i>		25B. NAME OF REGISTRAR <i>Leonard J. Ruck, Inc</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc</i>		ADDRESS <i>Baltimore, Md.</i>	

12

September 1988

Philip J. Vent

Maryland

Baltimore

3908 Case Avenue

11/19/86

Italy

Theresa Sodano

Union Memorial Hospital

Male White Widowed

Michael J. Vent

UNITED STATES OF AMERICA

THOMAS H. HARRIS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09613		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09613	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ethel Waltz		2. DATE AND HOUR OF DEATH 9/21/66 1 7 05 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		A. STATE B. COUNTY Maryland Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-11			
		D. STREET ADDRESS (If rural, give location) 3816 Grantley Road Balto, Md. 21215			
5. SEX Fe	6. RACE Cauc	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 9-1-1899	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT Home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME George Jacob White		14. MOTHER'S MAIDEN NAME Myrtle P. Anderson		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Bradley H. Waltz 3816 Grantley Road	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Pulmonary failure (B) DUE TO Metastatic Carcinoma (C) DUE TO Carcinoma of Ovary		INTERVAL BETWEEN ONSET AND DEATH 1 hr Many years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/21/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-23-66		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 22 1966			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Ellsworth Amcott			
25D. ADDRESS 4600 Liberty Hghts. Ave					



# FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department				Registered No. 66 09614	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Josephine ROSALIE Boggs	
2. DATE AND HOUR OF DEATH		9-18-66 5 <sup>10</sup> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
UNIVERSITY HOSPITAL BALTIMORE		Md. BALTIMORE 26-10			
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEPARATED	
8. DATE OF BIRTH 4-13-39		9. AGE (In years last birthday) 27		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph TAMBURELLO		14. MOTHER'S MAIDEN NAME HELEN CACHON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-36 0766		17. INFORMANT ADDRESS MOTHER	
18. 704.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) Gastro-intestinal hemorrhage		60 hours	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Cushing's syndrome		9 months	
		(C) Pemphigus vulgaris		3 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No	
21D. TIME OF INJURY (APPROX.) NONE		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-16-66 19 66 to 9-18-66 19 66, that (I) (we) last saw the deceased alive on 9-18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Timothy Kenney Gray M.D.				23B. DATE SIGNED 9-18-66	
23C. PHYSICIAN'S NAME (Type) TIMOTHY KENNEY GRAY M.D.				23D. ADDRESS UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/21/66		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cem	
24D. LOCATION (City, town, or county) Balto Md.		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. FUNERAL DIRECTOR Joseph J. Ziemer		24H. ADDRESS 123 S. Conowingo		24I. DATE 9-22-66	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Eva Bean		9/20/66 4:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224				A. STATE Md. Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1021 W. Stockton St. #21217			
5. SEX female	6. RACE negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH 2/8/06	9. AGE (In years last birthday) 60 yr.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown			10B. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) VIRGINIA	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. unknown	17. INFORMANT ADDRESS BALTIMORE, MD. 21224 RECORDS-BCH-4940 EASTERN AVENUE.			
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <u>arteriosclerotic cardiovascular disease</u> DUE TO (B) <u>hypertension</u> DUE TO (C) <u>hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH 3 months years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/15 1966 to 9/20 1966, that (I) (we) last saw the deceased alive on 9/20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Bruce M. Dow				23B. DATE SIGNED 9/20/66		23C. PHYSICIAN'S NAME (Type) BRUCE M. DOW	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-24-66		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1966		25B. NAME OF REGISTRAR D. E. J. Talbot		25C. FUNERAL DIRECTOR George Nelson		25D. ADDRESS 1348 Chatham St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09616	
BIRTH NO. 66 09616		CERTIFICATE OF DEATH		Registered No. 66 09616	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Smith, George</u>		2. DATE AND HOUR OF DEATH <u>9/20/66</u> <u>19:30 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>16-02</u> D. STREET ADDRESS (If rural, give location) <u>1134 Calhoun St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>12/22/25</u>	9. AGE (In years last birthday) <u>40</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Clinton Smith</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Clark</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>220-22-8929</u>		17. INFORMANT ADDRESS <u>Hospital Record</u>	
18. <u>2043</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>central hemorrhage</u> DUE TO (B) <u>thrombocytopenia</u> DUE TO (C) <u>acute myelogenous leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 hr</u> <u>7 day?</u> <u>3 mos?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>None</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/19</u> <u>1966</u> to <u>9/20</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>9/20</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. E. Zisch</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/20/66</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-24-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 24 1966</u>		25B. NAME OF REGISTRAR <u>George E. Kelly, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>George Kelson 1348 N. Calhoun St.</u>	

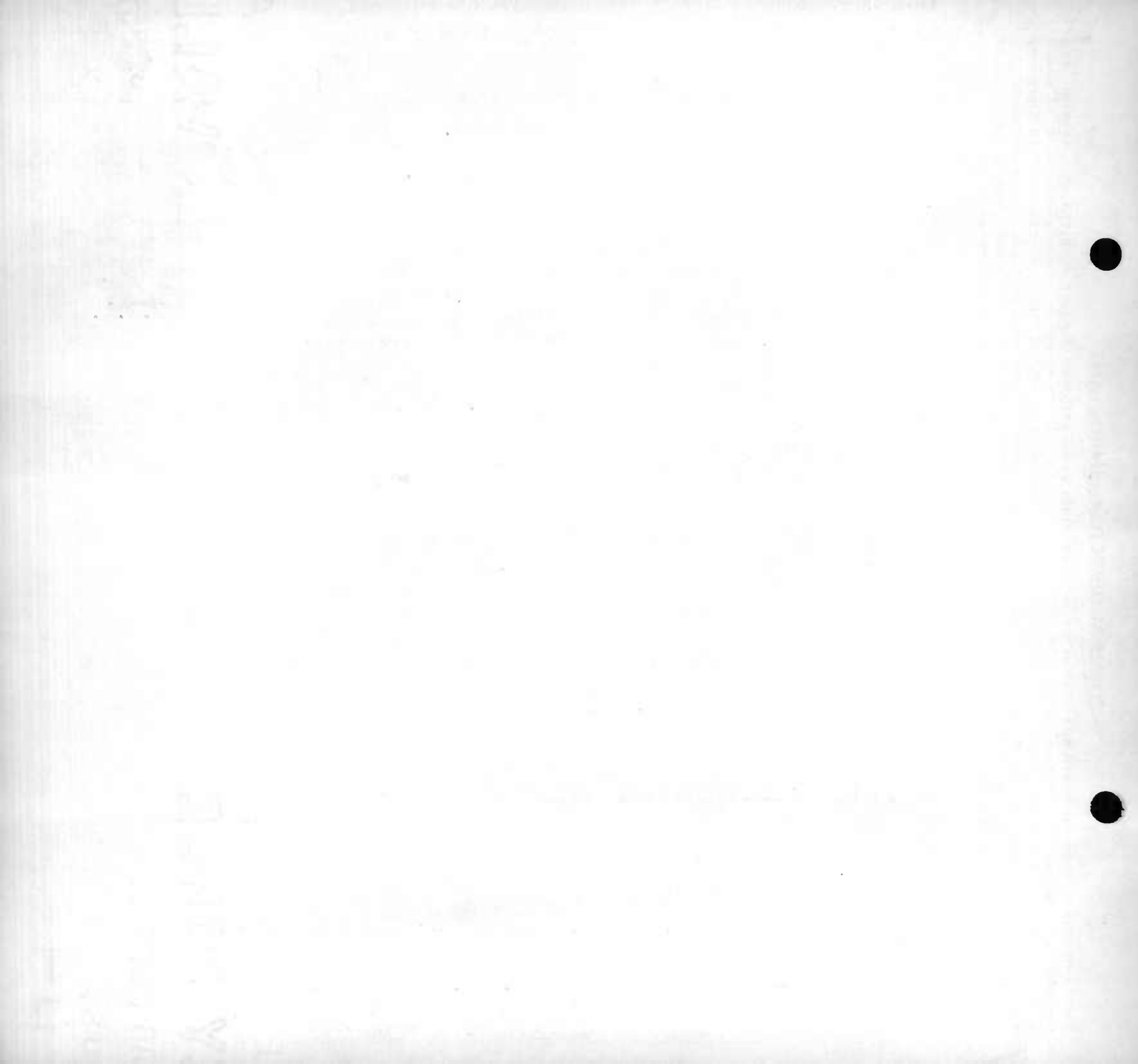




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09617</u>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <u>66 09617</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
1. NAME OF DECEASED (Type or Print) <u>Lavinia Hunt</u>			2. DATE AND HOUR OF DEATH <u>9-24-66</u> <u>3 P.</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>3925 Fairview Avenue</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>15-04</u> D. STREET ADDRESS (If rural, give location) <u>2042 Ruxton Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>6-22-01</u>	9. AGE (In years lost birthday) <u>65</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Bermuda Islands</u>	
13. FATHER'S NAME <u>Charles Simons</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>A. Sinclair Swann 2042 Ruxton Avenue</u>	
18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>C V A</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ARTERIOSCLEROSIS</u>			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH <u>15 HRS.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>9-20-1966</u> to <u>9-21-1966</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>9-21-1966</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>E. C. CLAY</u>				23B. DATE SIGNED <u>9-23-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. C. CLAY</u>		23D. ADDRESS <u>3405 GARRISON BLVD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-24-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>	
24D. LOCATION <u>Arbutus Maryland</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>SEP 24 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farnham</u>		25C. FUNERAL DIRECTOR ADDRESS <u>GEORGE G. KELSON 1348 N. CALHOUN ST.</u>			



FUNERAL DIRECTOR: IMPORTANT  
This certificate must be approved by the Medical Examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

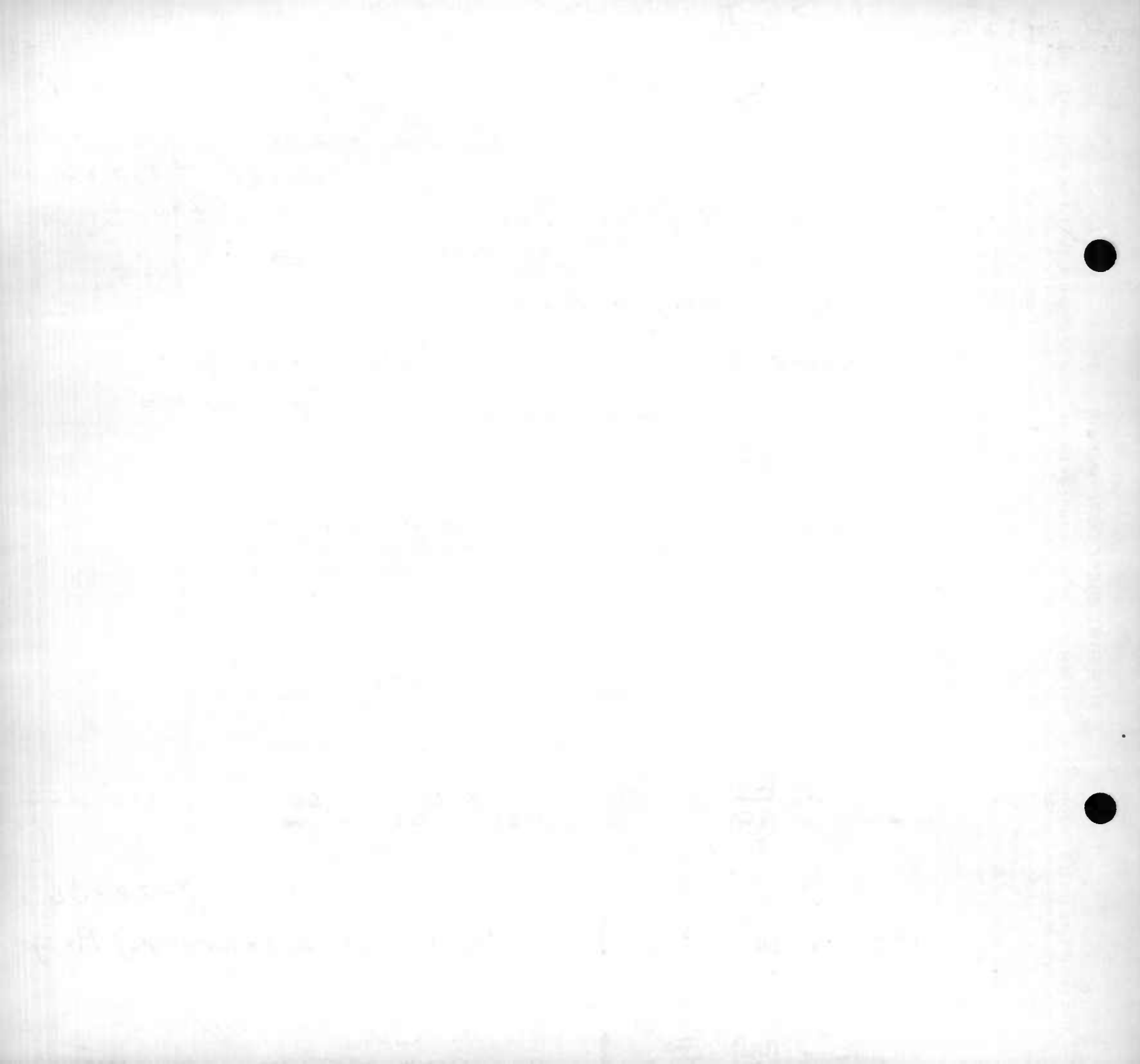
BIRTH NO. 66 09618		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09618	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ANTONIO PAPPAS</b>		2. DATE AND HOUR OF DEATH <b>9-21-66 8:40 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Church Home + Hosp</b>		A. STATE <b>Maryland</b>		B. COUNTY	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		D. STREET ADDRESS (If rural, give location) <b>3806 Bank St. (24)</b>			
5. SEX <b>M</b>		6. RACE <b>W W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	
8. DATE OF BIRTH <b>1-27-10</b>		9. AGE (In years last birthday) <b>56</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Restaurant</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Greece</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Sophochley Pappas</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-09-0415</b>		17. INFORMANT <b>Chart</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Edema</b>		19. CAUSE OF DEATH <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
22. I certify that (I) (this hospital) attended the deceased from <b>9-20 1966</b> to <b>9-21 1966</b> , that (I) (we) last saw the deceased alive on <b>9-21 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. SIGNATURE <b>[Signature]</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		24. DATE SIGNED <b>9-22-66</b>	
25. PHYSICIAN'S NAME (Type) <b>D. A. E. Subong, Jr.</b> M.D.		26. ADDRESS <b>Church Home + Hosp</b>			
27. BURIAL CREATION, REMOVAL (Specify) <b>Burial</b>		28. DATE <b>9/24/66</b>		29. NAME OF CEMETERY OR CREMATORY <b>St. Andrew Russian Orth. Cemetery</b>	
30. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		31. STATE <b>Md.</b>			
32. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		33. NAME OF REGISTRAR <b>[Signature]</b>		34. FUNERAL DIRECTOR <b>Nicholas T. Matthews</b>	
35. ADDRESS <b>3021 Eastern Ave., Baltimore</b>					

10-4-66 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09619		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09619	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <i>Howard Blevins</i>		2. DATE AND HOUR OF DEATH <i>9-21-66 3:50 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp.</i>		A. STATE <i>Maryland</i> B. COUNTY <i>25-05</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21226</i>			
		D. STREET ADDRESS (If rural, give location) <i>1808 Hazel Street</i>			
5. SEX <i>M.</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Divorced</i>	8. DATE OF BIRTH <i>11-15-08</i>	9. AGE (In years last birthday) <i>57</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CARPENTER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>NAT. Maintenance</i>		11. BIRTHPLACE (State or foreign country) <i>Va.</i>	
13. FATHER'S NAME <i>James E.</i>		14. MOTHER'S MAIDEN NAME <i>Nora Sparks</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family - Same</i>	
18. <i>451X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <i>Memorhage</i> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Repeated Abdominal</i> DUE TO <i>Costal Anemia</i>			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (we) (this hospital) attended the deceased from <i>9-21-1966</i> to <i>9-21-1966</i> , that (we) lost saw the deceased alive on <i>9-21-1966</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9-22-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Consular Dr. C. Palad, Jr.</i>		23D. ADDRESS <i>South Baltimore General Hosp.</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>		24B. DATE <i>9/26/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodward</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>48 City - 237 Patapsco Ave</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

64-32133 66 09620		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09620	
BIRTH NO.		CERTIFICATE OF DEATH		X	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		CHARLES ASHMORE		9-21-66 10 <sup>05</sup> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND		B. COUNTY BALTIMORE	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		COCKEYSVILLE 53-00	
		D. STREET ADDRESS (If rural, give location)		521 IVY HILL ROAD	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
MALE	WHITE	NEVER MARRIED	11-25-64	1	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
			Maryland	U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		ADDRESS	
ALFRED ASHMORE		DORIS CAPELLE		521 Ivy Hill Road Cockeysville, Md.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		
No		None	Alfred Ashmore		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) Acute Leukemia		~ 7 wks.	
ANTECEDENT CAUSES		(B) Gm negative sepsis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-5 19 66 to 9-21 19 66, that (I) (we) last saw the deceased alive on 9-21 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Herbert Kaiser				9-21-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
HERBERT KATZER		THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	9/24/66	Dulaney Valley Mem. Gardens		Cockeysville, Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
		H. J. Schmitt		Owings Mills, Md.	

HERBERT KEISER

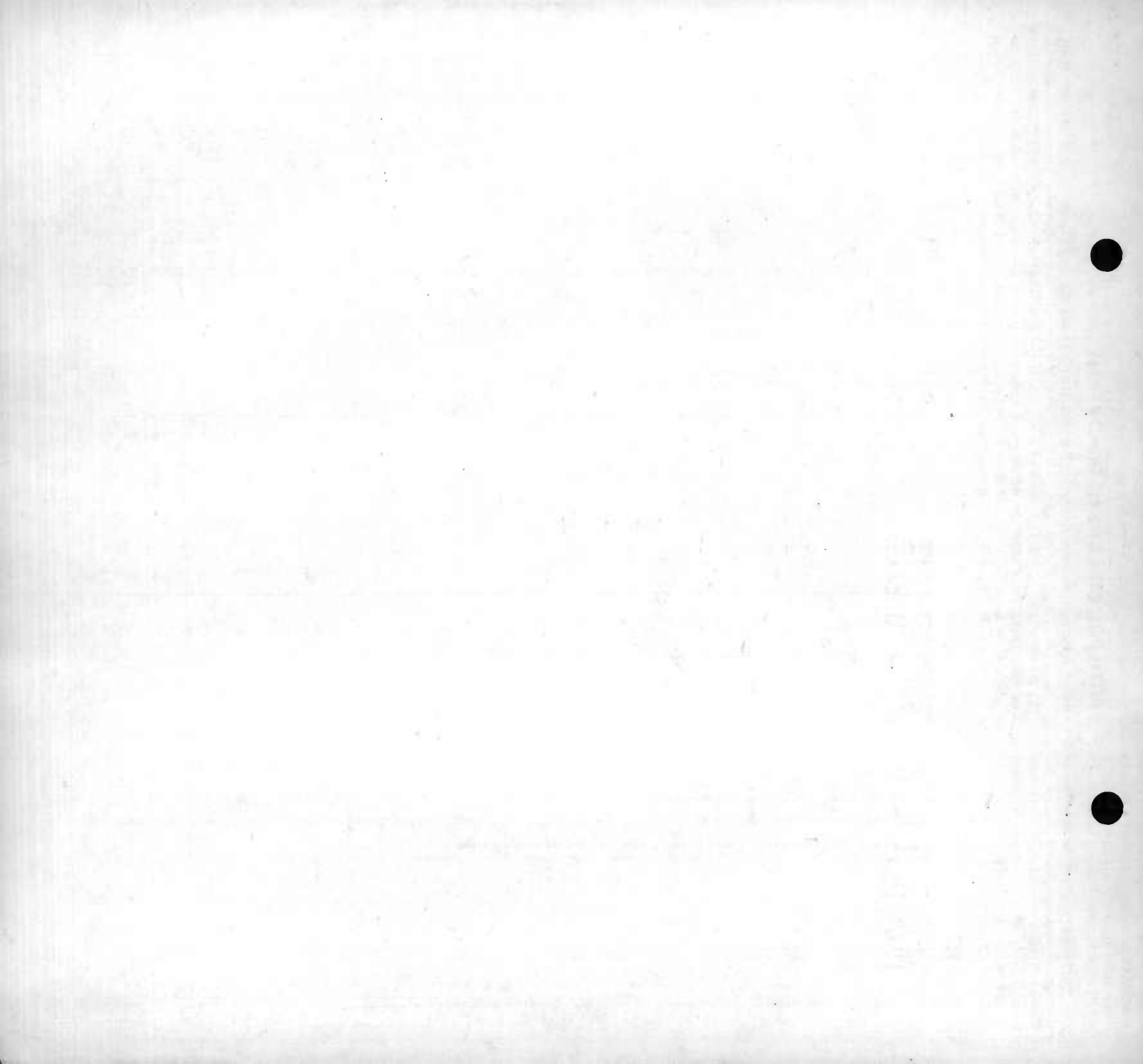
Herbert Keiser



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09621		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09621	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) EMMA HAYES		
2. DATE AND HOUR OF DEATH Sept. 15, 1966. 6:20 P. M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 2922 Arunah Ave. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Md. D. STREET ADDRESS (If rural, give location) 16-06			FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2922 Arunah Ave		
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 12-2-1883	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? US			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Nursing Home		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Bronchial Pneumonia DUE TO (B) Cardio-Vascular Disease DUE TO (C) Over 3 months			INTERVAL BETWEEN ONSET AND DEATH 3 days		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arterio-Sclerosis		
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ✓		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 14, 1966 to Sept. 15, 1966, that (I) (we) last saw the deceased alive on Sept. 15, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frank N. Ogden				23B. DATE SIGNED Sept. 19, 66	
23C. PHYSICIAN'S NAME (Type) FRANK N. OGDEN		23D. ADDRESS M.D. 2701 N. Calvert St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-19-66		24C. NAME of CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 26 1966			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR C. W. Wright			
25D. ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09622		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09622	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>FREDRICK C PEET</b>			2. DATE AND HOUR OF DEATH <b>9-21-66</b>   <b>12:20 P M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>13-06</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>3644 Hickory Avenue</b>		
5. SEX <b>MALE</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>6-19-82</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACTOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>WALES</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. —</b>
13. FATHER'S NAME <b>UNKNOWN (DEC)</b>			14. MOTHER'S MAIDEN NAME <b>LOUISA TRAIL (DEC)</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-10-2179</b>	17. INFORMANT ADDRESS <b>CHART —</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>420.17-181.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Acute Myocardial Infarction</b> (A) DUE TO <b>ASCEND.</b> (B) DUE TO <b>—</b> (C) DUE TO <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>Plan 1</b>		
19. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		
20A. AUTOPSY? (Yes or No) <b>Yes</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>—</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (A) (this hospital) attended the deceased from <b>9-12</b> 19 <b>66</b> to <b>9-21</b> 19 <b>66</b> , that (B) (we) last saw the deceased alive on <b>9-21</b> 19 <b>66</b> and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert L. Doyle</b> M.D.			23B. DATE SIGNED <b>9-21-66</b>		
23C. PHYSICIAN'S NAME (Type) <b>—</b>			23D. ADDRESS M.D. <b>—</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>24 Sept 66</b>		24C. NAME OF CEMETERY or CREMATORY <b>St Marys Cem. (Hampden)</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>SEP 25 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Burgee Funeral Home 3631 Falls Rd</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>				Registered No. <u>577523</u>	
BIRTH NO. <u>66 09623</u>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>Behrens, August W.</u>				2. DATE AND HOUR OF DEATH <u>9-22-1966</u> <u>10</u> <u>P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Belton Hill Nursing Home</u> <u>Lafayette Street</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Baltimore, Md.</u> B. COUNTY <u>Baltimore, Md.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore, Md.</u> D. STREET ADDRESS (If rural, give location) <u>104 W. Randall St.</u>	
5. SEX <u>Male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Wid.</u>	8. DATE OF BIRTH <u>10-19-1881</u>	9. AGE (In years last birthday) <u>84 yrs.</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist (Foreman)</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Machine Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>August Behrens</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Catherine Bell</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>212-18-4714</u>			17. INFORMANT <u>Wm. E. Behrens - (Son)</u> <u>4205 Canal Beach Rd</u> <u>Baltimore, Md 21226</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Generalized arteriosclerosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Relativity of reprobation</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>None</u>				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>9/23/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 2</u> 19 <u>66</u> to <u>Sept 22</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 22</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Albert M. Mact</u> M.D.				23B. DATE SIGNED <u>9/23/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Albert M. Mact</u> M.D.				23D. ADDRESS <u>2 E. Broad St Baltimore Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Sept 26, 1966</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Green Haven Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Greenbelt, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1966</u>			
25B. NAME OF REGISTRAR <u>Dr. E. E. Evans</u>		25C. FUNERAL DIRECTOR <u>Curtis E. Evans</u> ADDRESS <u>14005 CHARLES ST - 21230</u>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09624		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09624	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LARRABEE, JESSIE C.		2. DATE AND HOUR OF DEATH 9/22/66 7:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND 21 229 B. COUNTY Balto			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MARYLAND 21229		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00			
D. STREET ADDRESS (If rural, give location) 629 PLYMOUTH ROAD					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-05-07	9. AGE (In years lost birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INS. HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY FIREMAN - 2225 EISE ST.		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME ROBERT GRENSHAW (DEC'D)		14. MOTHER'S MAIDEN NAME UNKNOWN (DEC'D)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN 219-20-5568		17. INFORMANT ADDRESS HOSPITAL SLIP - ST AGNES HOSPITAL	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) SUBARACHNOID HEMORRHAGE - 1 DAY DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 22, 19 66 to SEPTEMBER 22, 19 66, that (X) (we) last saw the deceased alive on SEPTEMBER 22, 19 66 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE JUAN J. CABRERA - M.D.		23B. DATE SIGNED 9-23-66		23C. PHYSICIAN'S NAME (Type) JUAN J. CABRERA - M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-26-66		24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 26 1966		25B. NAME OF REGISTRAR J. J. J.		25C. FUNERAL DIRECTOR WEBER FUNERAL HOME 5311 EDMONDSON AVE	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09625</u>	
BIRTH NO. <u>66 09625</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<u>GENEVIEVE L. BRESLIN</u>		<u>SEPT. 23, 1966</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  (If not in hospital or institution, give street address or location)		A. STATE <u>MARYLAND</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
<u>3617 WILKENS AVENUE 21229</u>		D. STREET ADDRESS (If rural, give location) <u>3617 WILKENS AVENUE 21229</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>4-1-1909</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>LOUIS C. TATUM</u>			14. MOTHER'S MAIDEN NAME <u>MARY E. HEPDING</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT ADDRESS <u>MR. JAMES P. BRESLIN, 3617 WILKENS AVENUE #29</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>410X I</u> <u>Rheumatic Heart Disease 20 yrs. with mitral insufficiency</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<u>0</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>January 1958</u> 19 to 19 that (I) (we) last saw the deceased alive on <u>September 18</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph D B King</u>				23B. DATE SIGNED <u>9/23/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH D. B. KING</u>		23D. ADDRESS <u>222 W. COLD SPRING LANE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-26-66</u>		24C. NAME of CEMETERY or CREMATORY <u>LOUDON PARK CEMETERY</u>	
				24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <u>HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229</u>	

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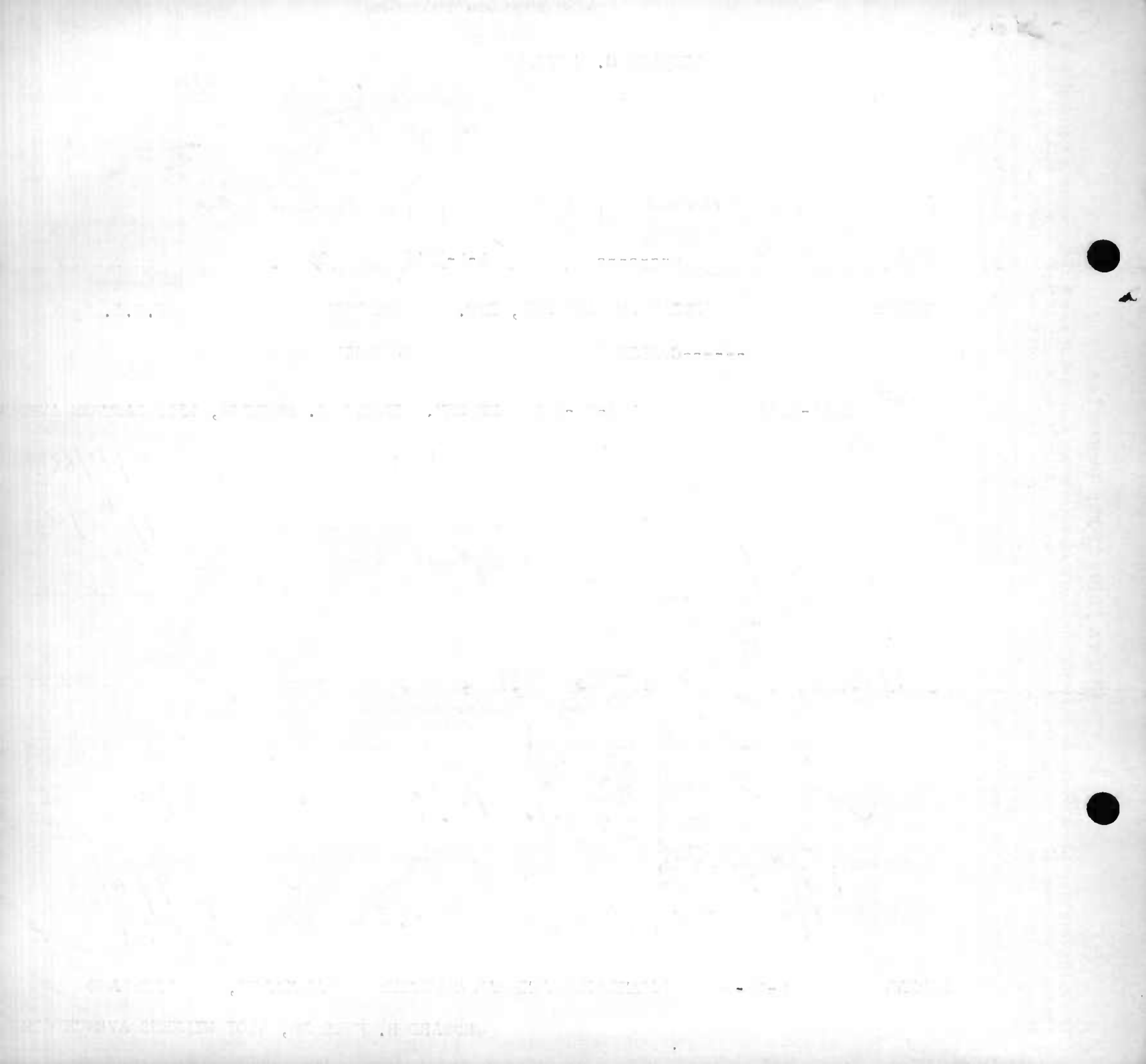
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# FUNERAL DIRECTOR: IMPORTANT

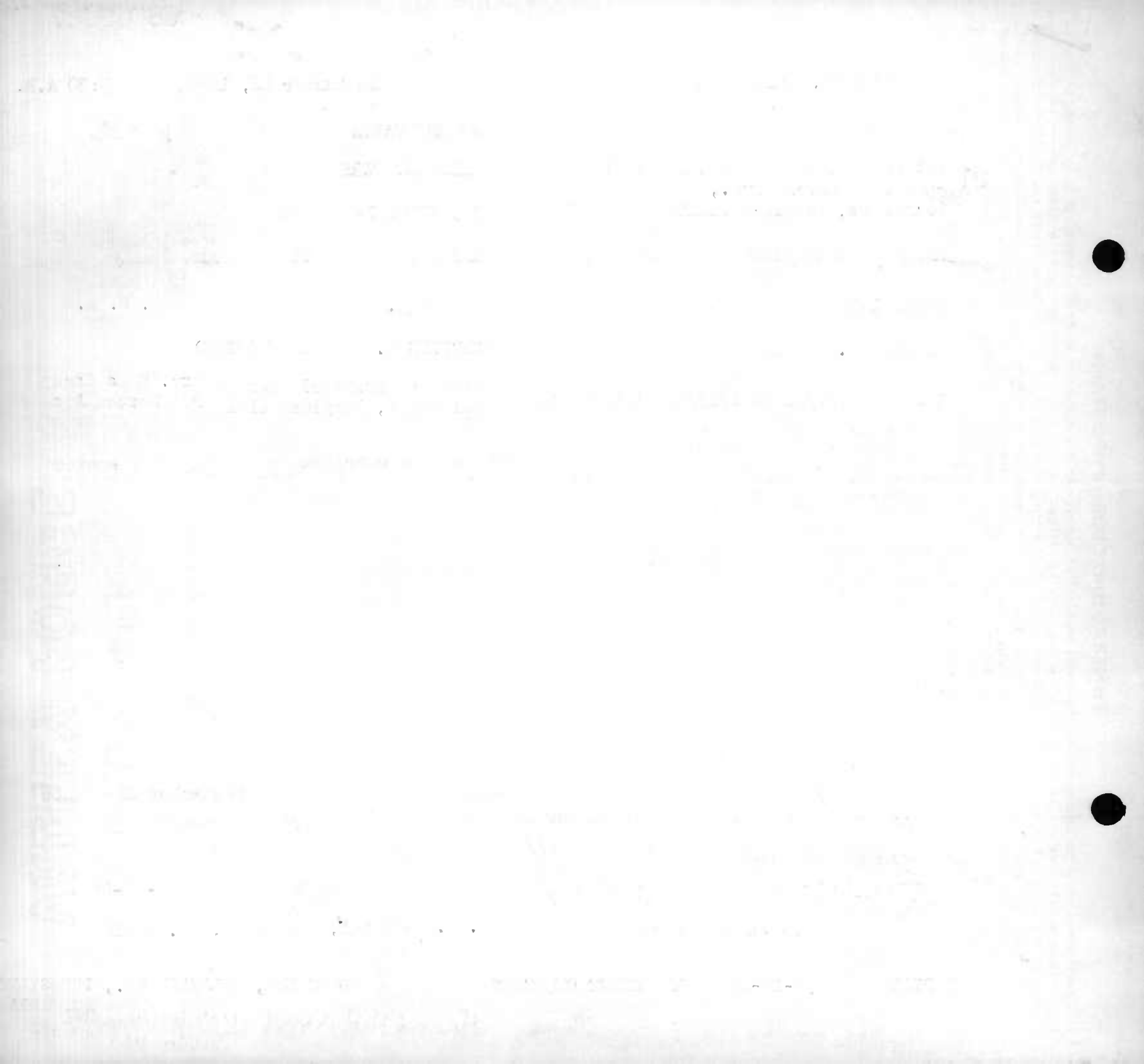
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 09626					CERTIFICATE OF DEATH		Registered No. 66 09626		
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <b>Cullison Mr Richard</b>					2. DATE AND HOUR OF DEATH <b>9/20/66 4:50 PM</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Church &amp; home hospital 100 N. Broadway, Baltimore</b>					A. STATE <b>Maryland</b>				
					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 3-01</b>				
					D. STREET ADDRESS (If rural, give location) <b>1513 Eastern Ave.</b>				
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>-----</b>		8. DATE OF BIRTH <b>2-2-1927</b>	9. AGE (In years last birthday) <b>39</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WELDER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>KRICK OF MARYLAND, INC.</b>			11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>-----CULLISON</b>					14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 1944-1946</b>					16. SOCIAL SECURITY NO. <b>214-20-5120</b>		17. INFORMANT <b>MR REV. WILLIAM C. BOWLING, 1513 EASTERN AVENUE</b>		
18. <b>330X1</b>					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(A) DUE TO <b>Cerebral haemorrhage 9/18/66</b>				
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					(B) DUE TO <b>9/20/66</b>				
ANTECEDENT CAUSES					(C) <b>Ruptured Aneurysm of circle of Willis??</b>				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>9/20/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Respiratory arrest</b>			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from <b>9/18/66</b> 19 <b>66</b> to <b>9/20</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/20/66</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>K-M. Anandaniah</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/20/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>I. C. MARIANO K.N. ANANDANIAH M.D.</b>					23D. ADDRESS <b>Church home &amp; hospital Baltimore Md.</b>				
24A. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-23-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
25A. DATE RECD. BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Hubbert</b>			25C. FUNERAL DIRECTOR ADDRESS <b>HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29</b>				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

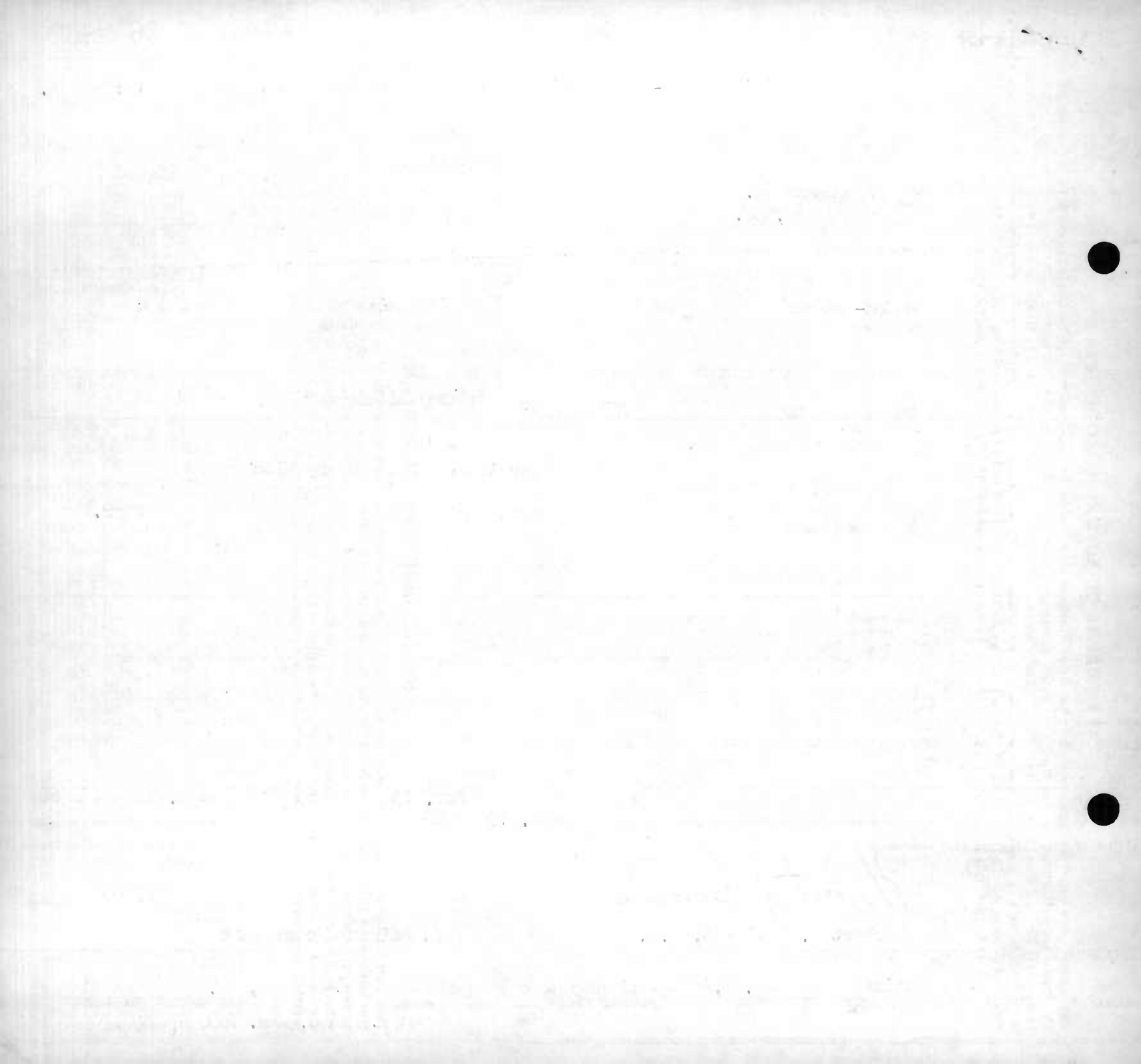
BIRTH NO. 66 09627		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09627	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>TOOMER, WILLIAM CLYDE</b>			2. DATE AND HOUR OF DEATH <b>September 22, 1966</b>   <b>9:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Maryland 21218</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>PENNSYLVANIA</b> B. COUNTY <b>V-35</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>MILLMONT PARK</b> D. STREET ADDRESS (If rural, give location) <b>305 VIRGINIA AVENUE</b>		
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>DIVORCED</b>	8. DATE OF BIRTH <b>5/30/09</b>	9. AGE (In years lost birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CHESTER, PENNSYLVANIA</b>	
13. FATHER'S NAME <b>WILLIAM D. TOOMER</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b> <b>2/2/42 to 1/13/45</b>		16. SOCIAL SECURITY NO. <b>195 05 8248</b>		17. INFORMANT <b>Veterans Hospital Records</b> Mrs. Edna Casey <b>Baltimore, Maryland 21218</b> 504 Morton Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Bronchogenic carcinoma</b> (A) DUE TO (B) DUE TO (C) DUE TO <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 Months</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>August 4</b> 19 <b>66</b> to <b>September 22</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>September 22</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James Sam Louie</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>9-22-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>James Sam Louie</b>		23D. ADDRESS <b>V. A. Hospital, Baltimore, Md. 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-26-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>LAWNCROFT CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BOOTHLYN, DELAWARE CO., PENNSYLVANIA</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b> 4107 Wilkens Ave <b>Balto, Md 21229</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09628		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09628	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Adella (Miliauskiene-Miller) Milauskas</i>		2. DATE AND HOUR OF DEATH <i>September 22, 1966</i>   <i>10:25</i> A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>917 Bayard St. Baltimore, Md.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>917 Bayard Street</i>			
5. SEX <i>Female</i>	6. RACE <i>Wh</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>April 12 1896</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailor-Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>		11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>217 01 8387</i>		17. INFORMANT <i>Anthony Milauskas 917 Bayard St</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of the ovary with metastasis</i>		CAUSE OF DEATH (A) <i>Carcinoma of the ovary with metastasis</i> DUE TO (B) <i>metastasis</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>9/25/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Nov. 13 19 65</i> to <i>Sept. 22 19 66</i> , that (I) (we) last saw the deceased alive on <i>Sept. 19 19 66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Herbert J. Levickas</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>9/23/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Herbert J. Levickas, M.D.</i>		23D. ADDRESS <i>1073 Maiden Choice Lane</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Sep. 26, 1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Most Holy Redeemer Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>SEP 25 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Thomas J. Kenny, Inc.</i>		ADDRESS <i>1600 Hollins St</i>			





5-450

66 09629

BALTIMORE CITY HEALTH DEPARTMENT

66 09629

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) MAJOR L. SLOAN 2. DATE AND HOUR PRONOUNCED DEAD September 24, 1966 6:55 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4001 W. Franklin Street C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-07

D. STREET ADDRESS (If rural, give location) 4001 W. Franklin Street

5. SEX Male 6. RACE Colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED 8. DATE OF BIRTH May 3-1886 9. AGE (In years last birthday) 80 10. MONTHS Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. JANITOR RAILROAD 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) GREENVILLE S.C. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME GABRIEL SLOAN 14. MOTHER'S MAIDEN NAME Jane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 215-09-0332 17. INFORMANT GUSSE SLOAN 4001 W. Franklin St ADDRESS

18. CAUSE OF DEATH 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER DATE SIGNED 9/25/66

23A. BURIAL CREMATION, REMOVAL (Specify) Buried 23B. DATE 9/25/66 23C. NAME OF CEMETERY or CREMATORY ARBUTUS MEM. PK 23D. LOCATION (City, town, or county) (State) ARBUTUS - BALTO MD 27

24A. DATE REC'D BY HEALTH DEPT. SEP 26 1966 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR 24D. ADDRESS

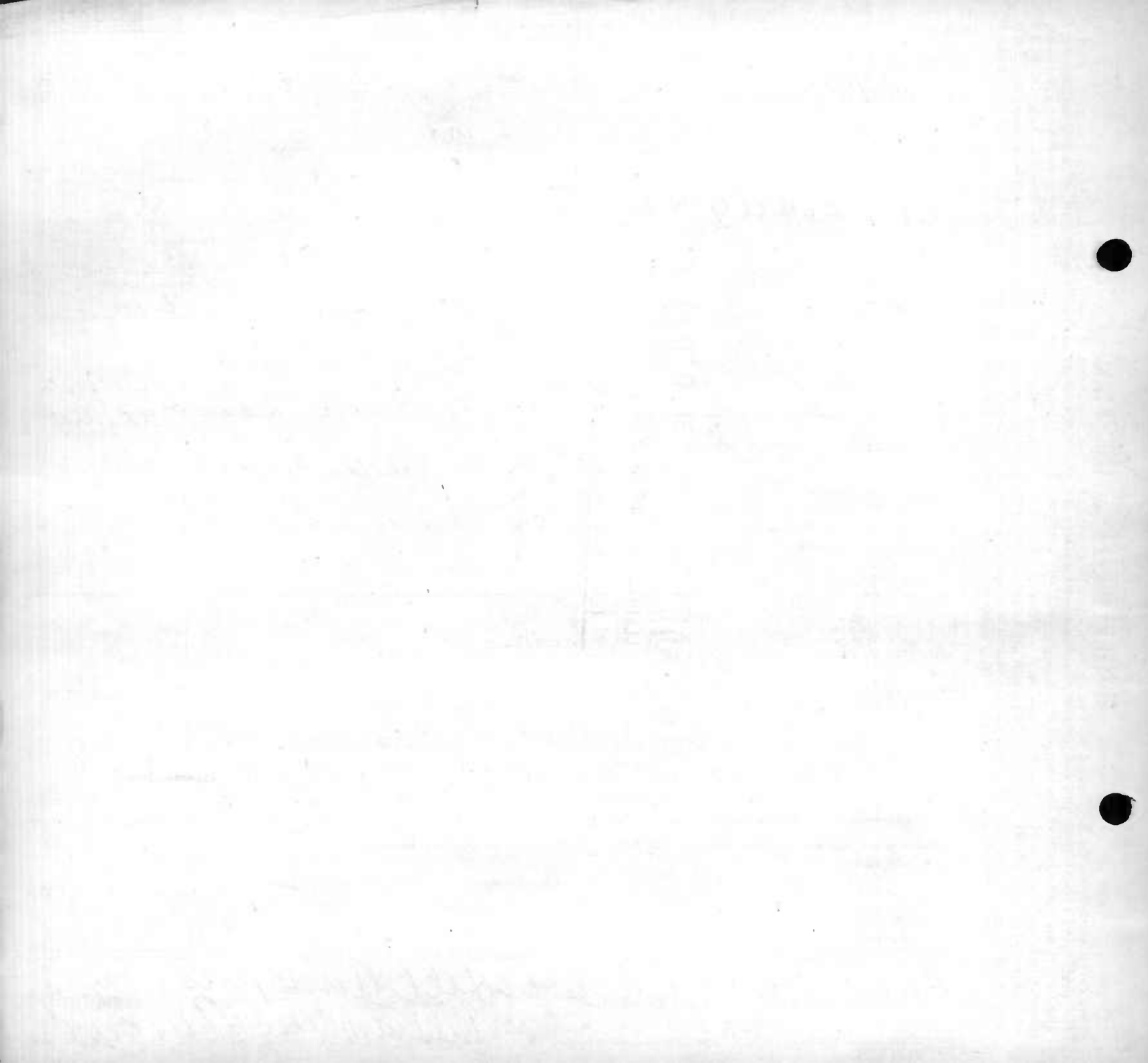


To be returned by Medical Examiner

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09630		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09630	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>MARY Thomas</i>		Sept 18, 1966 10:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Md. B. COUNTY AA	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		52-00	
University Hospital		D. STREET ADDRESS (If rural, give location)		Plaza Manor Nsg. Home	
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4/10/73	9. AGE (In years lost birthday) 93	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John H. Thomas		14. MOTHER'S MAIDEN NAME Elizabeth Queen		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-54-0819-T		17. INFORMANT George Thomas	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		ADDRESS 60 Larkins St	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) Cerebrovascular Accident		INTERVAL BETWEEN ONSET AND DEATH 4 days -	
ANTECEDENT CAUSES		(B) ARTERIOsclerosis		-	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Advanced Age		-	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Fracture @ hip -			
19A. DATE OF OPERATION 9/11/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture @ hip		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing home		21C. WHERE DID INJURY OCCUR? Glen Burnie, Md -	
21D. TIME OF INJURY (APPROX.) 9 8 66 9:00 AM		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pt fell while getting out of bed	
22. I certify that (I) (this hospital) attended the deceased from 9/9 to 9/18 19 66 to 9/18 19 66, that (I) (we) lost saw the deceased alive on 9/9/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James D. Glasgow		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept 18, 1966	
23C. PHYSICIAN'S NAME (Type) James D. Glasgow		23D. ADDRESS M.D. University Hospital			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 9-26-66		24C. NAME OF CEMETERY or CREMATORY Brewer Hill Annapolis Md	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. SEP 26 1966			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 26 1966		William Rees #1 Annapolis Md			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. <span style="float: right;">66 09631</span>					
BIRTH NO. <b>66 09631</b>										
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) <b>Deborah Lockwood</b>		2. DATE AND HOUR OF DEATH <b>9/22/66</b>			10 <sup>18</sup> <b>AM.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>					A. STATE <b>Md.</b>					
(If not in hospital or institution, give street address or location)					B. COUNTY <b>Cecil</b>					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Cecilton</b>					
					D. STREET ADDRESS (If rural, give location) <b>Box 356</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never Married</b>		8. DATE OF BIRTH <b>5-19-52</b>		9. AGE (In years last birthday) <b>14</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>James R. Lockwood</b>					14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth O'Neal</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>James Robert Lockwood,</b>			ADDRESS <b>Cecilton, Md.</b>			
18. <b>204.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Monocytic Leukemia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>12 mos.</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES.</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Sept. 1</b> 19 <b>66</b> to <b>Sept. 22</b> 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Sept. 22</b> 19 <b>66</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.										
23A. SIGNATURE <b>Robb Moses</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>9/22/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Robb Moses</b>					23D. ADDRESS <b>The Johns Hopkins Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Sept. 26/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Galena Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Galena, Kent Co; Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>G. E. E. E.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Edward Fellows, Millington, Md. 21651</b>						







18 June 1915

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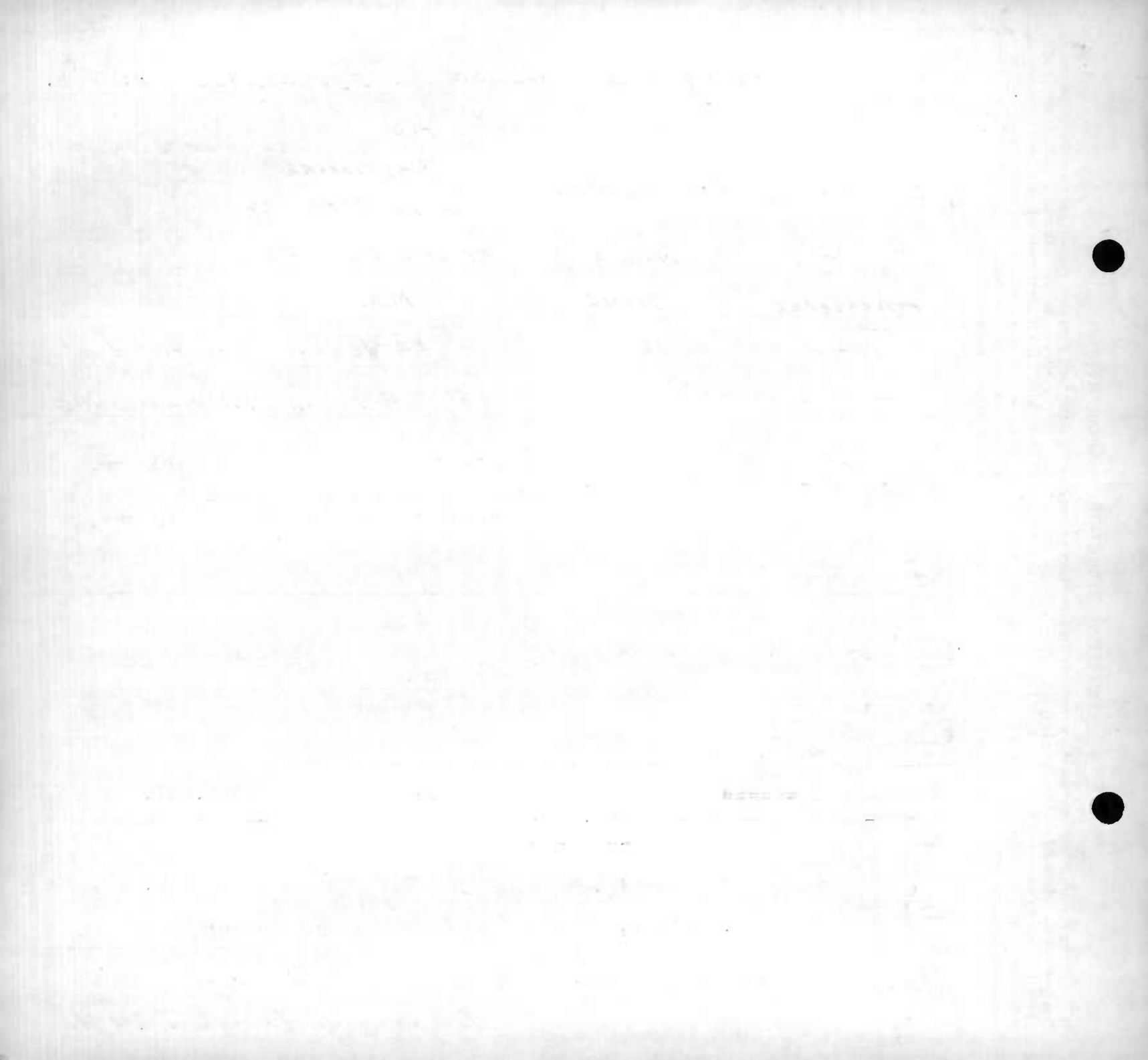
18 June 1915



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 66 09633		CERTIFICATE OF DEATH		Registered No. 66 09633	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		MARY E. WELSH		2. DATE AND HOUR OF DEATH SEPT. 21, 1966 8:10 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MD.			
90 LONG GREEN NURSING HOME		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 4718 YORK RD.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH MARCH 15, 1886	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME PHILIP CAVANAUGH			
14. MOTHER'S MAIDEN NAME CATHERINE CAVANAUGH		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Thomas H. Berlin - 516 WINDWOOD AVE.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Hypertension DUE TO Arteriosclerotic cardiovascular renal disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 10 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(we)</del> attended the deceased from August 5, 1966 to Sept. 21, 1966, that (I) <del>(we)</del> last saw the deceased alive on Sept. 16, 1966 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE Lloyd E. Saylor		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Sept. 23, 1966	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor,		23D. ADDRESS M.D. 3902 Greenmount Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-24-66		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cem.	
24D. LOCATION (City, town, or county) (State) Elkhridge Md.		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR J. E. Saylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS J. E. Saylor, M.D.			



66 09634

BALTIMORE CITY HEALTH DEPARTMENT

66 09634

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Willie Lee Melvin

2. DATE AND HOUR PRONOUNCED DEAD

9/19/66 11:40 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1506 N. Broadway

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Aug. 23 1941

9. AGE (In years  
last birthday)

25

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Lumberbridge N.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Laven Melvin

14. MOTHER'S MAIDEN NAME

Lula Mae Lilly

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Goldie Melvin 2502 E. Chase St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Massive internal bleeding  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Stab wound of chest, involving the  
pulmonary artery

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

1506 N. Broadway

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
9 19 66 10:45 p.m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

stabbed during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/20/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Shipped

23B. DATE

9/23/1966

23C. NAME of CEMETERY or CREMATORY

Lanham Hill Cem.

23D. LOCATION

(City, town, or county)

(State)

Hope Co. N.C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

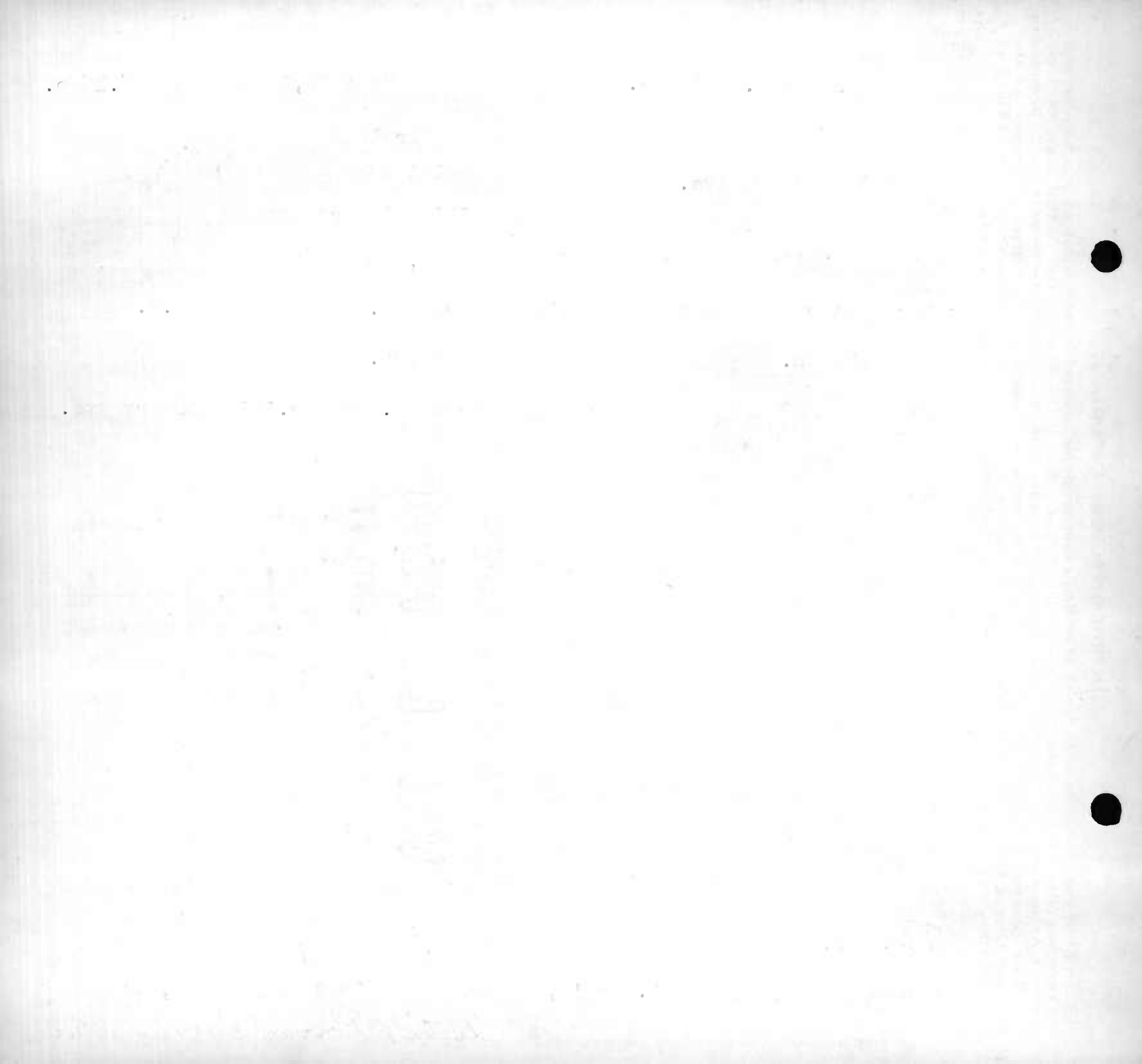
Williams Funeral Home 319 N. Schroeder St.

SEP 28 1966

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 09635	
CERTIFICATE OF DEATH				Registered No. _____	
BIRTH NO. _____		M.E. CASE NO. _____		1. NAME OF DECEASED (Type or Print) <b>Wilbur T. Metzger.</b>	
2. DATE AND HOUR OF DEATH <b>Sept 22, 1966</b>   <b>5.15 p. m.</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3938 Hickory Ave.</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3938 Hickory Ave</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>May 28, 1904</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Main Post Office</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Unknown.</b>		14. MOTHER'S MAIDEN NAME <b>Unknown.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Bertha M. Metzger.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>420.14-002.1</b> <b>Cerebral Occlusion</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>Other significant conditions contributing to the death but not related to the disease or condition causing it.</b> <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>13-07</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Thomas G. Abbott</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9-23-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Thomas G. Abbott</b>		23D. ADDRESS <b>4509 Liberty Hwy etc etc</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/26/66</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Mary's, Hampden</b>	
24D. LOCATION (City, town, or county) (State) <b>3900 Roland Ave, Balto Md</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>SEP 26 1966</b>		25C. FUNERAL DIRECTOR <b>Justin E. Donovan</b>			
25D. ADDRESS <b>3818 Roland Ave</b>					

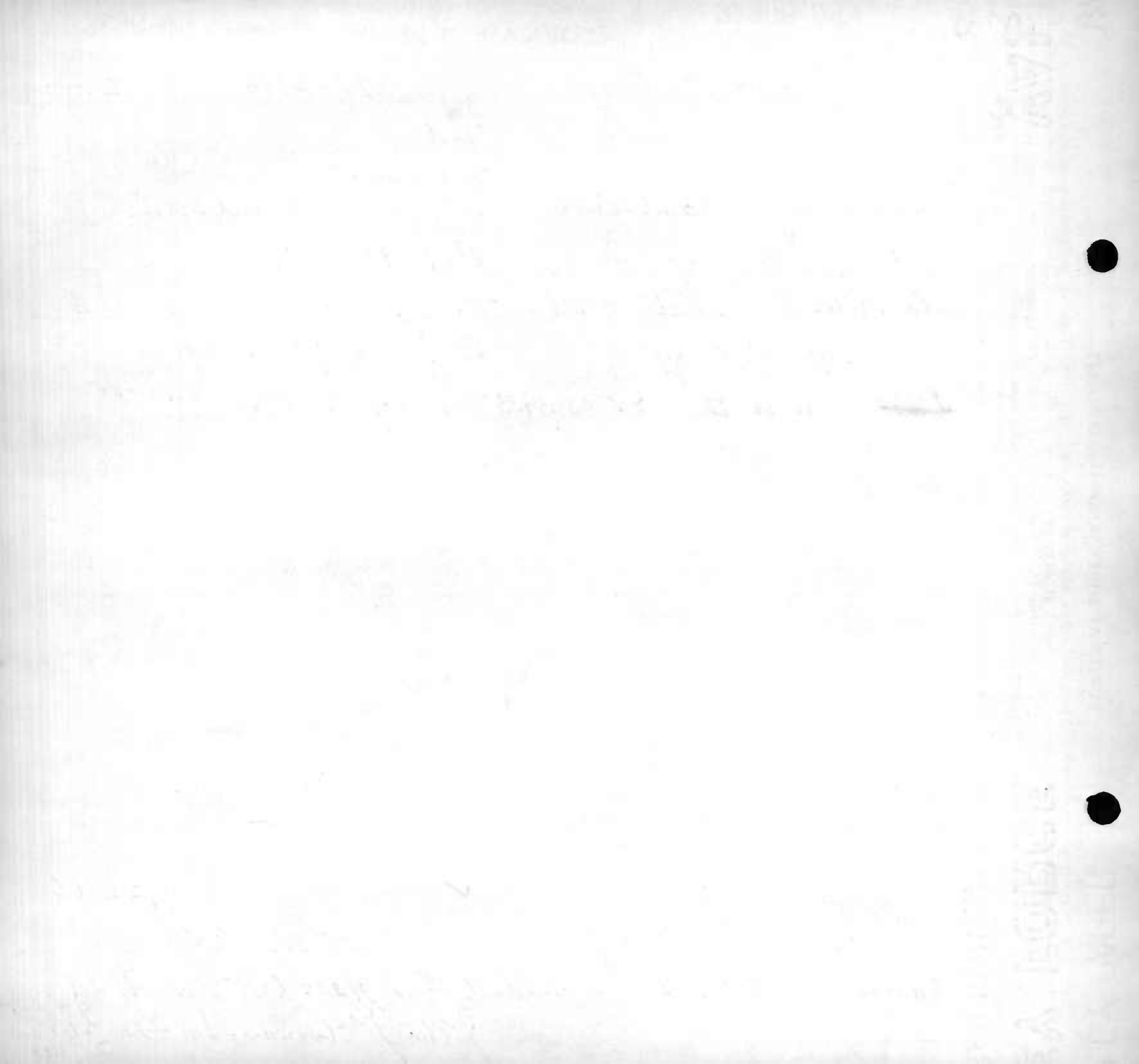


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09636	
BIRTH NO.				66 09636	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>John M. Day</i>			2. DATE AND HOUR OF DEATH <i>9/22/66</i> <i>2 A. M.</i>		
3. PLACE OF DEATH <i>BALTIMORE, MARYLAND</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i> <i>401 Long Island Ave</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>401 Long Island Ave</i>		
5. SEX <i>Male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>8/19/1909</i>	9. AGE (In years last birthday) <i>57</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auditor</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>State of Md.</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>
13. FATHER'S NAME <i>Delancey W. Day</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES</i> <i>W.W. II</i>			16. SOCIAL SECURITY NO. <i>215-03-3933</i>		17. INFORMANT <i>Mrs Mary A. Day</i> ADDRESS <i>above</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>420.1</i> <i>Cerebral Occlusion</i>			CAUSE OF DEATH (A) DUE TO <i>Cerebral Occlusion</i> (B) DUE TO <i>Coronary Occlusion</i> (C) DUE TO <i>A.S.D. with hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>4 years</i> <i>8 years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May</i> 19 <i>56</i> to <i>Sept 22</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Sept 22</i> 19 <i>66</i> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Pamela P. Alagia</i> M.D.				23B. DATE SIGNED <i>9/22/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>PAMELA P. ALAGIA</i> M.D.				23D. ADDRESS <i>3326 Frederick Ave</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/24/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>4300 Old Baltimore Rd.</i>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <i>John J. Corwin</i>		25C. FUNERAL DIRECTOR <i>John J. Corwin + Son Inc</i>			
25D. ADDRESS <i>23, md.</i>					

SEP 26 1966



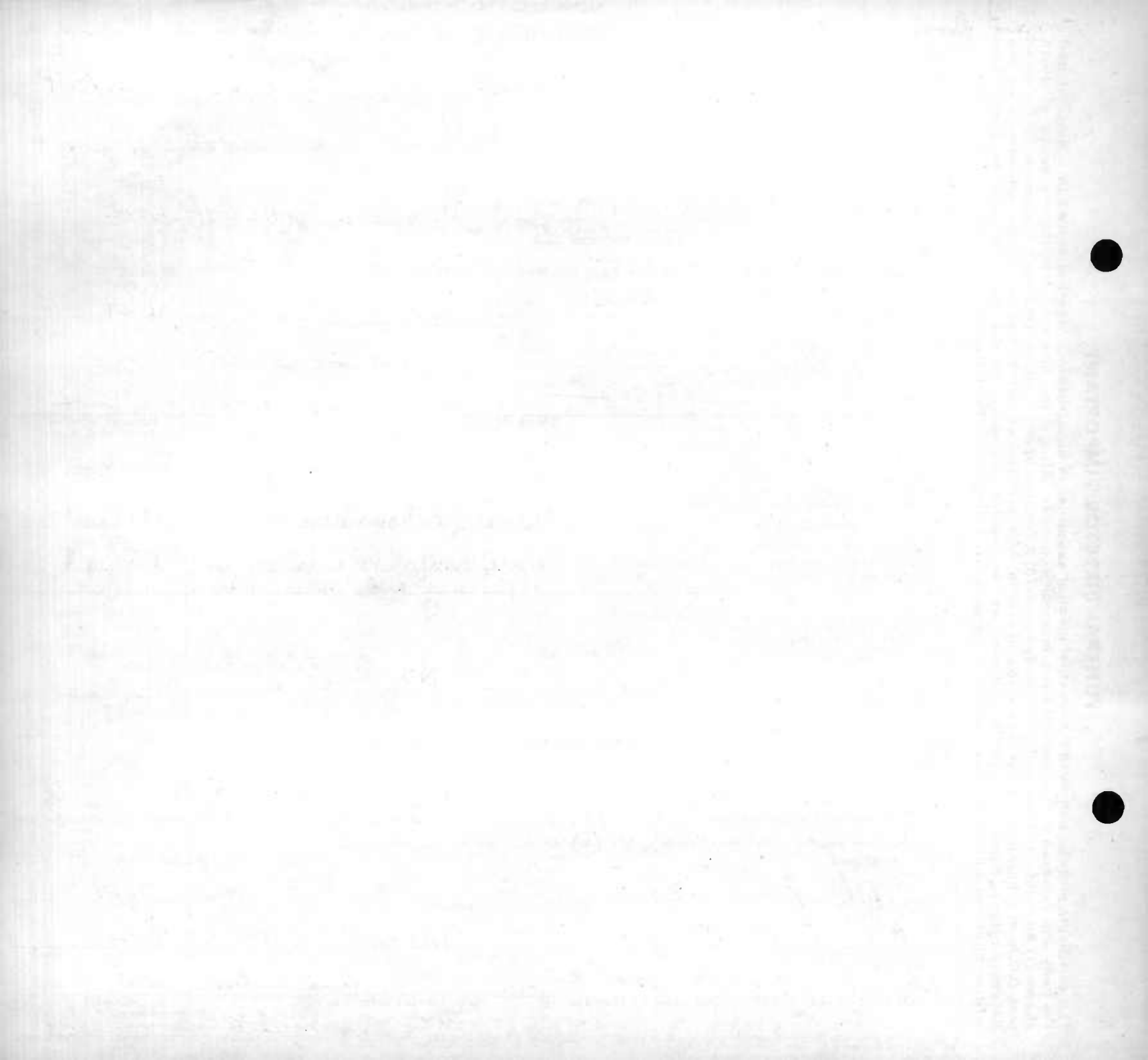




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 09637		66 09637		66 09637	
M.E. CASE NO.				BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
GRANITO SPERANZA FRANCES				9/19/66 5:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
UNIVERSITY HOSPITAL				Md Balto	
5. SEX 6. RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
F W SINGLE				53-00	
8. DATE OF BIRTH 9. AGE (In years last birthday)				D. STREET ADDRESS (If rural, give location)	
11-13-13 52				ROSEWOOD STATE HOSPITAL	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
NONE				ITALY	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?	
NONE				USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
PASQUALA GRANITO				VINCENTA VIELONK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
NO				17. INFORMANT ADDRESS	
18. 32551				Theresa Bleno - 3203 Boyers Court	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO	
II				(C) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				10 yrs (2)	
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)	
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				22. I certify that (1) (this hospital) attended the deceased from 9/2 1966 to 9/19 1966	
23A. SIGNATURE				23B. DATE SIGNED	
Kurt P. Sligar				9/19	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Kurt P. Sligar				UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE	
Burial				9-22-66	
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
Mt. Olive				Randalltown, Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR ADDRESS				25D. DATE SIGNED	
25E. NAME OF REGISTRAR				25F. DATE SIGNED	
25G. NAME OF REGISTRAR				25H. DATE SIGNED	
25I. NAME OF REGISTRAR				25J. DATE SIGNED	
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38O. NAME OF REGISTRAR				38P. DATE SIGNED	
38Q. NAME OF REGISTRAR					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 09638	
<b>1. NAME OF DECEASED</b> (Type or Print) <u>RACHEL BARNES</u>				<b>2. DATE AND HOUR OF DEATH</b> <u>9/21/66 4:15 P.M.</u> M.			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BON SECOURS HOSPITAL</u>				<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Carroll</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>SYKESVILLE MD.</u> D. STREET ADDRESS (If rural, give location) <u>18 CENTRAL AVENUE</u>			
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED, NEVER MARRIED</b> WIDOWED, DIVORCED (specify) <u>MARRIED</u>	<b>8. DATE OF BIRTH</b> <u>1/30/1888</u>	<b>9. AGE</b> (In years, last birthday) <u>78</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>WILLIAM LEIGHT</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>ATMANA LYTHE</u>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>217-40-6476</u>		<b>17. INFORMANT ADDRESS</b> <u>MR. HORPEL BARNES - BATHO., MD.</u>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>CAUSE OF DEATH</b> (A) <u>CONGESTIVE HEART FAILURE</u> DUE TO (B) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (C) <u>METASTATIC CARCINOMA IN LIVER, PRIMARY NOT DETERMINED</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 Months</u>  <u>YEARS</u>  <u>—</u>	
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
<b>19A. DATE OF OPERATION</b> <u>2</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY</b> (Yes or No) <u>yes</u>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <u>yes</u>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b>		(If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that</b> <u>(X)</u> (this hospital) attended the deceased from <u>9/21/66</u> 19 <u>66</u> to <u>9/21/66</u> 19 <u>66</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>9/21/66</u> 19 <u>66</u> and that in <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death.							
<b>23A. SIGNATURE</b> <u>L. Z. [Signature]</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		<b>23B. DATE SIGNED</b> <u>9/21/66</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>JAMIE BRATHIN</u> M.D.				<b>23D. ADDRESS</b> <u>BON SECOURS HOSP</u>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>24B. DATE</b> <u>9-24-66</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Springfield Cemetery</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>Sykesville, Md.</u>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>SEP 26 1966</u>		<b>25B. NAME OF REGISTRAR</b> <u>Robert E. [Signature]</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Haight Funeral Home</u>			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09639		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09639	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Guy Gordon</b>		2. DATE AND HOUR OF DEATH <b>9-22-66 6<sup>30</sup> PM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 53-00</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224</b>		D. STREET ADDRESS (If rural, give location) <b>1 WILLOW AVENUE - 21206</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWER</b>	8. DATE OF BIRTH <b>11-4-96</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWENS YACHT CO</b>		11. BIRTHPLACE (State or foreign country) <b>HANOVER, PENNA</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>James Gordon</b>		14. MOTHER'S MAIDEN NAME <b>Florence CRAWFORD</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-14-4683</b>		17. INFORMANT ADDRESS <b>21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Carcinoma</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. CAUSE OF DEATH (A) DUE TO <b>10 unknown</b> (B) DUE TO (C)			
22. I certify that (1) (this hospital) attended the deceased from <b>7-20-66</b> 19 to <b>9-22-66</b> 19 that (1) (we) last saw the deceased alive on <b>9-22-66</b> 19 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>William A. Emerson</b>		23B. DATE SIGNED <b>9-22-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM A. EMERSON</b>		23D. ADDRESS <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE, BALTIMORE, Md. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>	24B. DATE <b>9/26/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Loudon PARK</b>	24D. LOCATION (City, town, or county) (State) <b>FREDERICK - BALTO - MD</b>		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR <b>2. E. J. [unclear]</b>	25C. FUNERAL DIRECTOR <b>[Signature]</b>		ADDRESS <b>1300 EUTAW PI.</b>	

James Gordon

214-14-011

11/11/11

THE NATIONAL JOURNAL

11/11/11

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09640				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09640	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Leroy Braxton</b>			
2. DATE AND HOUR OF DEATH <b>9-17-66 10:45 PM</b>				M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>5 SOUTH BOND STREET</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED SEP</b>	8. DATE OF BIRTH <b>11-8-21</b>	9. AGE (In years last birthday) <b>44</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>ERNEST BRAXTON</b>			14. MOTHER'S MAIDEN NAME <b>CLINCIE ELTON</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>243-28-1779</b>		17. INFORMANT <b>Genevieve Blount 1420 B. Highland Ave</b>			
18. <b>334 X 4 322.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular Insufficiency</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Vertebral Artery Insufficiency</b> <b>Chronic Alcoholism</b>				CAUSE OF DEATH (A) <b>Cerebrovascular Insufficiency</b> (B) <b>Vertebral Artery Insufficiency</b> (C) <b>Chronic Alcoholism</b>			
INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>9/24/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <b>7/26/66</b> to <b>9/17/66</b> and that (we) last saw the deceased alive on <b>9/17/66</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.							
23A. SIGNATURE <b>Murray A. Katz</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9/17/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MURRAY A. KATZ</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/24/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mount Clearing</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>Dr. J. E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Barlow H. Bauld</b>		25D. ADDRESS <b>1529 E. North Ave. Balt.</b>	

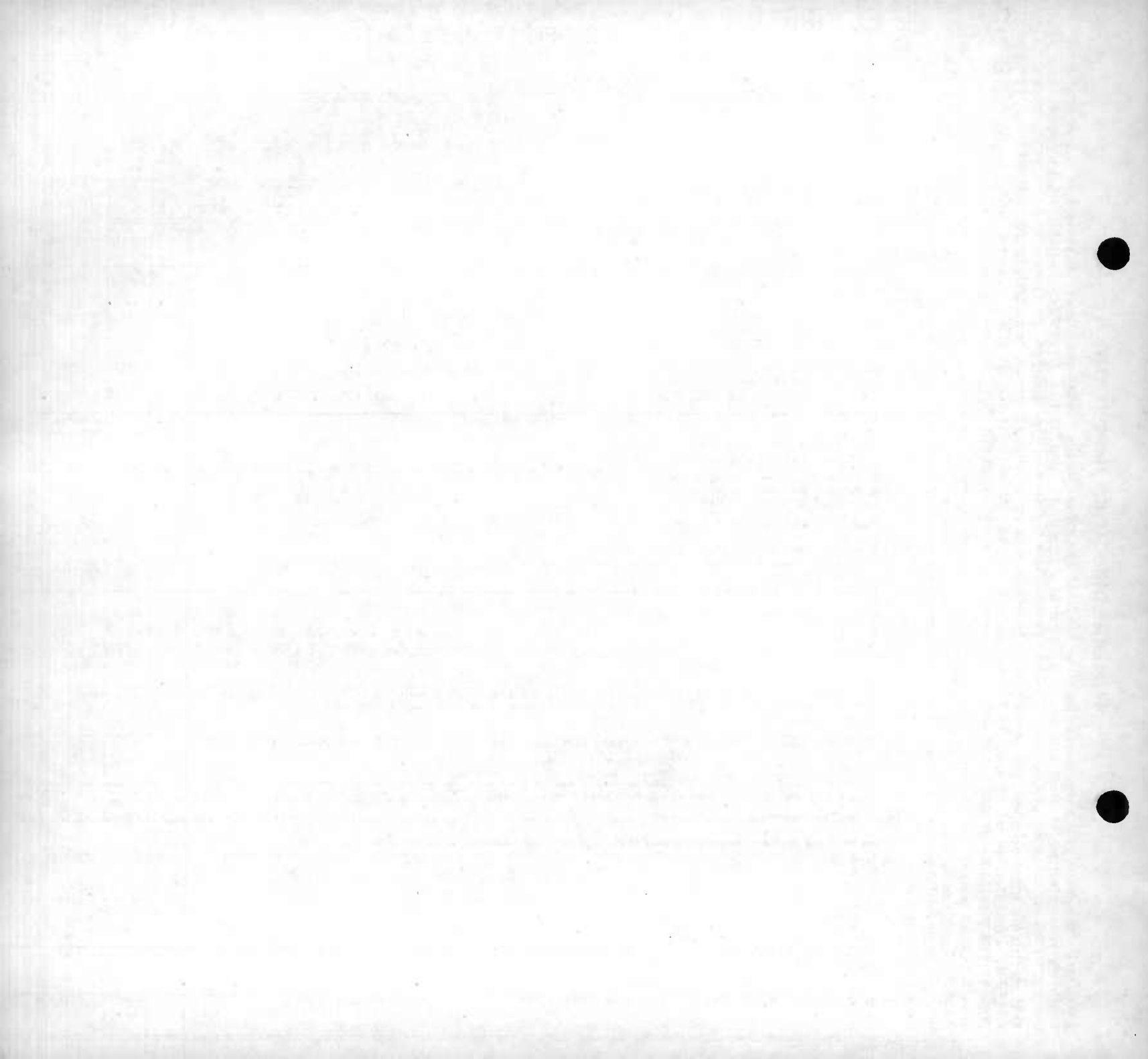




# FUNERAL DIRECTOR: IMPORTANT

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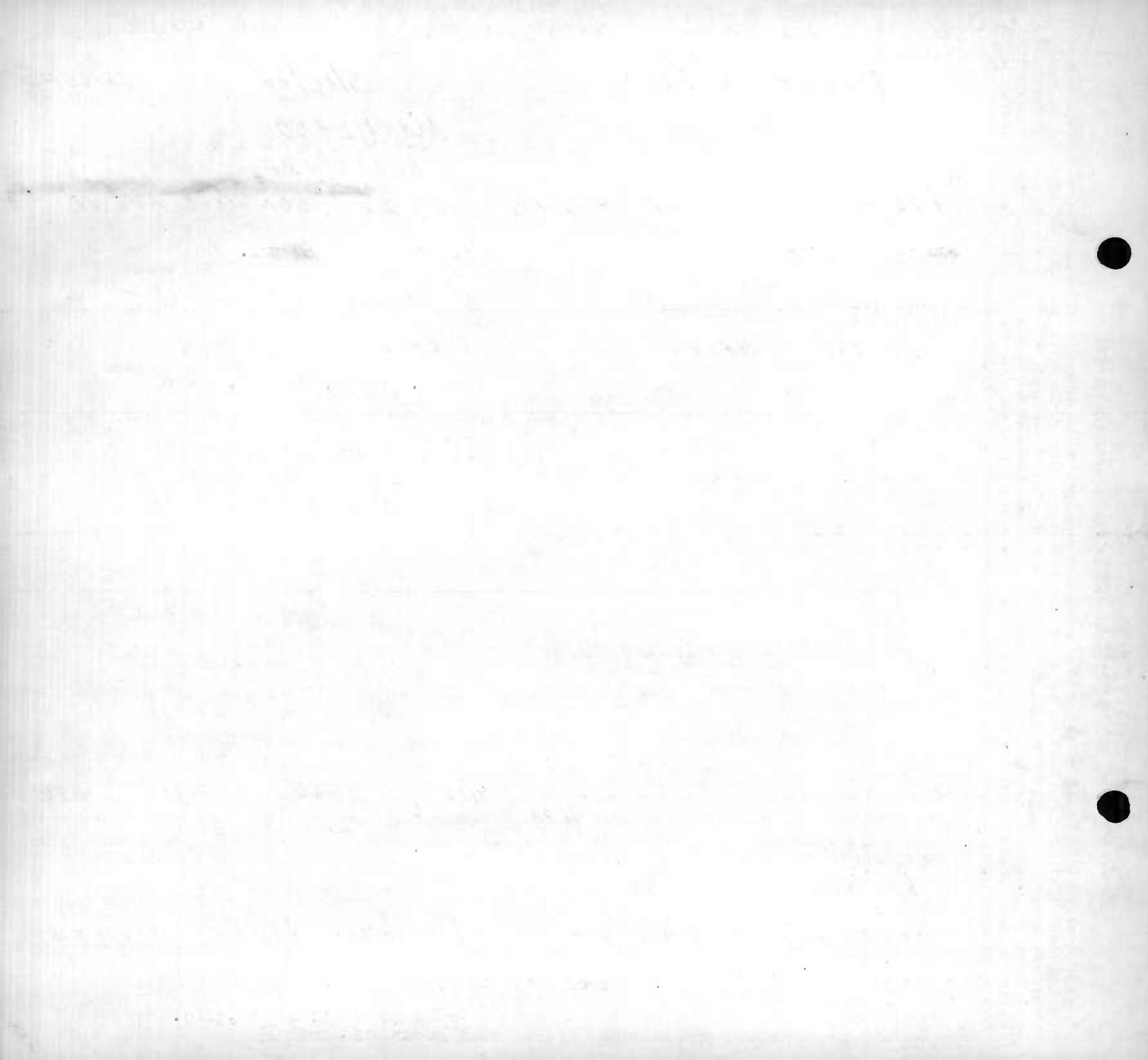
BIRTH NO. 66 09641		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09641	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CATHERINE YOKUBINAS		2. DATE AND HOUR OF DEATH 9/22/66 3 <sup>15</sup> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 37		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md., 21213 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 26-34 5003 E. Federal Street			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 3/20/1888	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Lithuania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ramanauskas		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT John Yokubinas, son, 5101 Wright Ave.	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) ACUTE PULMONARY EMBOLUS DUE TO (B) THROMBOPHLEBITIS DUE TO (C) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 5-7 DAYS YEARS 1-2 DAYS	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 9/21/1966 to 9/22/1966, that (1) (we) last saw the deceased alive on 9/22/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Bruce Gerber, M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/23/66	
23C. PHYSICIAN'S NAME (Type) S. BRUCE GERBER, M.D.		23D. ADDRESS 8045 WOODGATE CR. BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/24/66		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966			
25B. NAME OF REGISTRAR J. E. S. S.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09642</b>	
BIRTH NO. <b>66 09642</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>THELMA FREYER</b>		2. DATE AND HOUR OF DEATH <b>9/21/66 12:30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Franklin SQUARE HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>26-03</b> D. STREET ADDRESS <b>3727 BONVIEW AVE #13</b>		
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>1/14/07</b>	9. AGE (In years lost birth day) <b>59 yrs.</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>	
13. FATHER'S NAME <b>JOSEPH HALESL</b>			14. MOTHER'S MAIDEN NAME <b>GRACE NORWOOD</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>John A. Freyer, husband, above</b> <b>CAH</b>	
MEDICAL CERTIFICATION  18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial infarction</b>  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  20A. AUTOPSY? (Yes or No)  20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			INTERVAL BETWEEN ONSET AND DEATH		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/18</b> 19 <b>66</b> to <b>9/21</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/21</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Raymundo S. Magno</b> M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>RAYMUNDO S. MAGNO</b> M.D.		23D. ADDRESS <b>Franklin Square Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>SEP 21/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21/66</b>		25B. NAME OF REGISTRAR <b>S. Magno</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane #13</b>	



66 09643

BALTIMORE CITY HEALTH DEPARTMENT

66 09643

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WALTER KINNEMAN

2. DATE AND HOUR PRONOUNCED DEAD

September 18, 1966 4:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Iowa

B. COUNTY

V-13

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Clinton

D. STREET ADDRESS (If rural, give location)

2416 Chauncey Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

26 July 4/1943

9. AGE (In years  
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Sailor

10B. KIND OF BUSINESS OR INDUSTRY

U.S. NAVY

11. BIRTHPLACE (State or foreign country)

TAMPA, Florida

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Walter W. Kinneman

14. MOTHER'S MAIDEN NAME

Lois M. Madden

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

2 Feb. 1965

16. SOCIAL  
SECURITY NO.

483-52-1414

17. INFORMANT

ADDRESS

U.S. NAVY Records, USS TIDEWATER

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple Traumatic Injuries.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

Whitmore and Franklin St. 20-02

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

9

18

'66

A

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto into fixed object.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/18/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

23 Sept, 1966

23C. NAME OF CEMETERY or CREMATORY

CLINTON MEMORIAL PARK

23D. LOCATION

(City, town, or county)

(State)

Clinton, Iowa

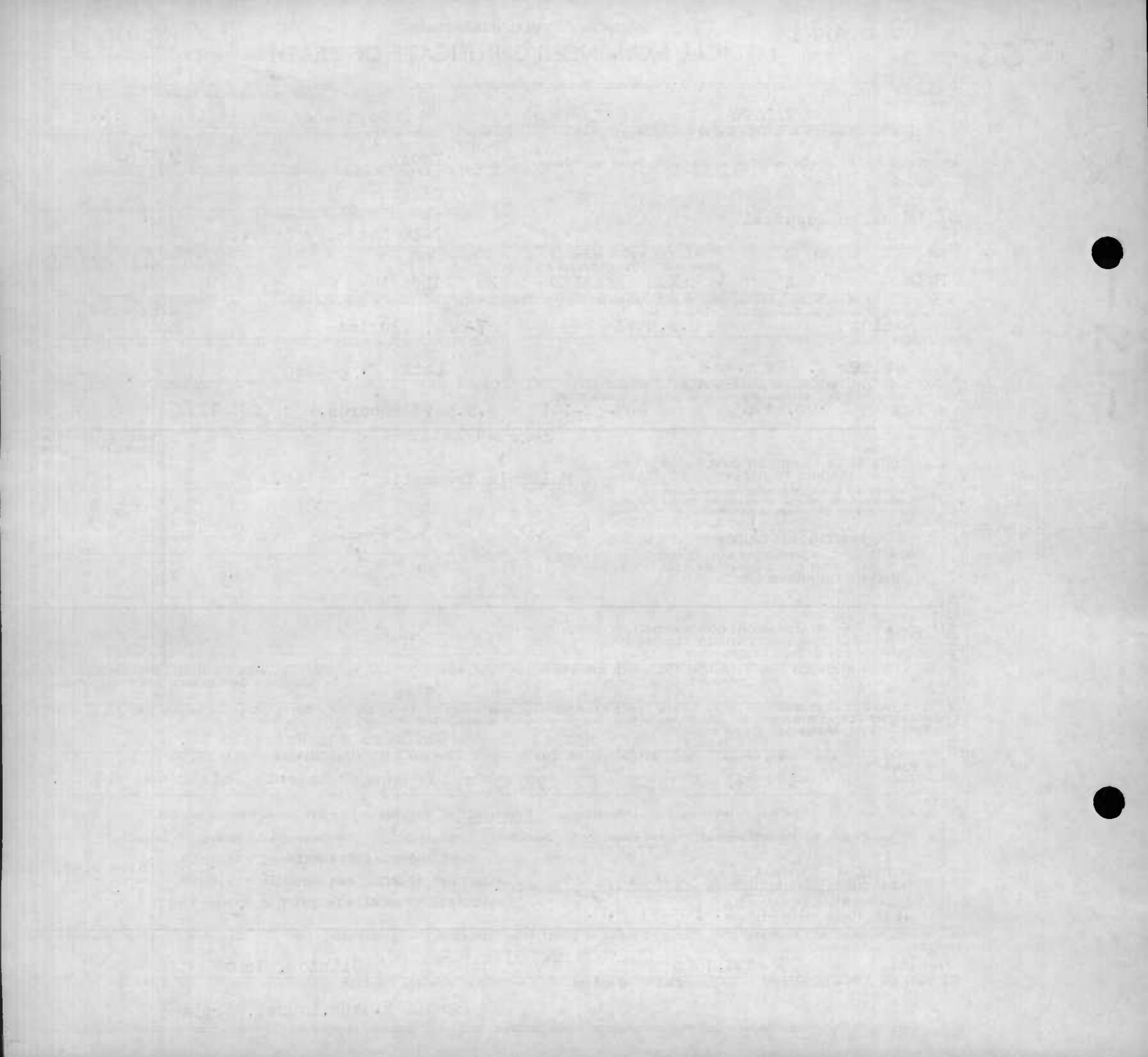
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Harold S. Wade, Laurel, Maryland



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09644</u>	
BIRTH NO. <u>66 09644</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Nina May Chapman</u>		2. DATE AND HOUR OF DEATH <u>Sept. 23, 1966</u>   <u>cir. 5:30 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>3103 Windsor Ave.,</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>3103 Windsor Ave.,</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 5, 1899</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Thomas E. Perry</u>		14. MOTHER'S MAIDEN NAME <u>Nina Cannon</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-01-7019</u>		17. INFORMANT ADDRESS <u>Nina June Chapman 3103 Windsor Ave.,</u>	
18. <u>443X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>Cardiac failure.</u>		CAUSE OF DEATH (A) DUE TO <u>Myocardial degeneration &amp; impaired valves.</u> (B) DUE TO <u>Arteriosclerosis with hypertension.</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>while sleeping</u> <u>?</u> <u>?</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 7, 1966</u> to <u>Sept. 23, 1966</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>Sept. 22, 1966</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <u>Maurice E. Shamer</u> M.D.				23B. DATE SIGNED <u>9-24-1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Maurice E. Shamer,</u>		23D. ADDRESS <u>3300 W. North Ave. 16 Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-26-1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olivet</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <u>G. Howard Strong</u>		25C. FUNERAL DIRECTOR ADDRESS <u>3207 W. North Ave.,</u>			







FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

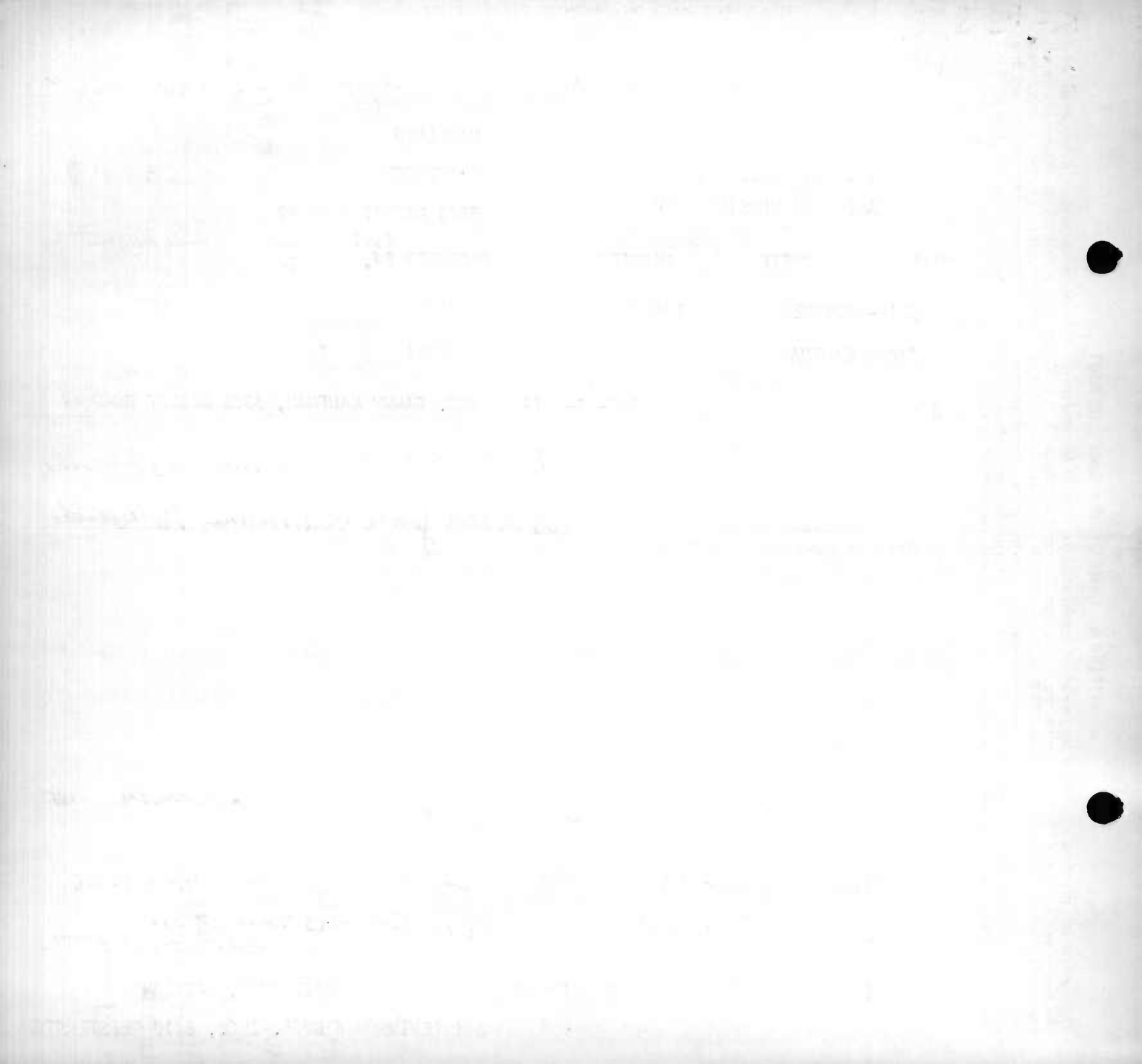
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 09645		CERTIFICATE OF DEATH		Registered No. 66 09645	
1. NAME OF DECEASED (Type or Print) <b>RUTH HELEN HOFFMAN</b>				2. DATE AND HOUR OF DEATH <b>9-23-66 1245 AM.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 SINAI HOSP.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 12-01</b> D. STREET ADDRESS (If rural, give location) <b>3900 N. CHARLES ST. APT 307</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>2-15-08</b>		9. AGE (In years last birthday) <b>58</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>		
13. FATHER'S NAME <b>LOUIS LESSER</b>				14. MOTHER'S MAIDEN NAME <b>MOLLIE RICKLES</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>MR. ELI HOFFMAN, 3900 NORTH CHARLES ST. APT 307</b>			
18. <b>7-20-11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST</b>				CAUSE OF DEATH (A) DUE TO <b>ACUTE MYOCARDIAL INFARCTION 6 DAYS</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>ASCVD</b>				YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>DUODENAL PEPTIC ULCER. 10 DAYS.</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>9-14 1966</b> to <b>9-23 1966</b> , that (I) (we) last saw the deceased alive on <b>9-23 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Alvin Schachter</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9-23-66</b>			
23C. PHYSICIAN'S NAME (Type) <b>ALVIN SCHACHTER M.D.</b>				23D. ADDRESS <b>SINAI HOSP.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/25/66</b>		24C. NAME of CEMETERY or CREMATORY <b>RIGA KURLANDER VEREIN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>John E. Tabor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

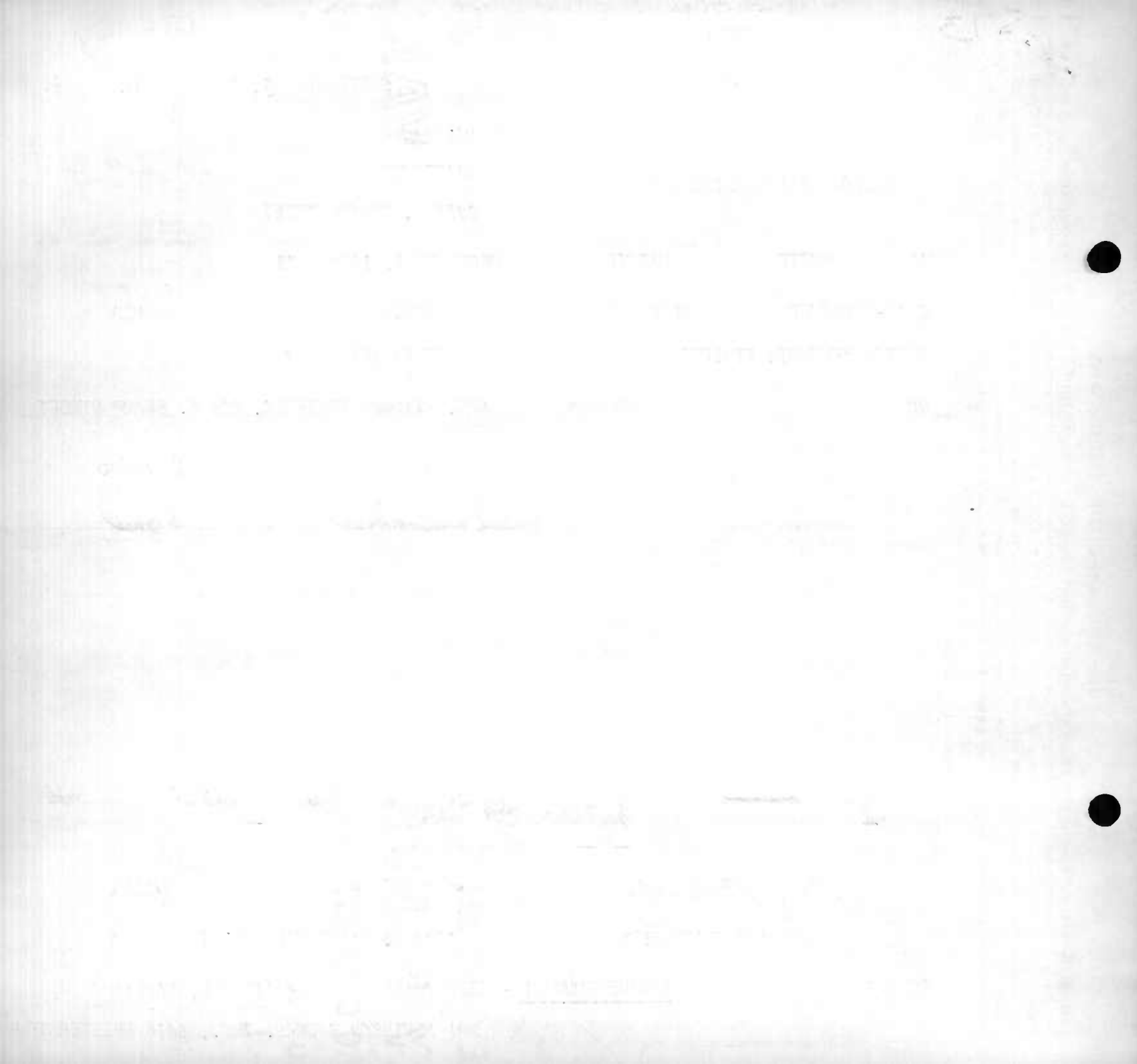
BALTIMORE CITY HEALTH DEPARTMENT									
66 09646					CERTIFICATE OF DEATH		Registered No. 66 09646		
BIRTH NO. 66 09646					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>SAMUEL KAUFMAN</b>					2. DATE AND HOUR OF DEATH <b>September 22, 1966 3 P. M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 4601 PALL MALL ROAD PALL MALL NURSING HOME</b>					A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto</b>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>				
					D. STREET ADDRESS (If rural, give location) <b>3305 MARNAT ROAD #9</b>				
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>1891 DECEMBER 24,</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF-EMPLOYED</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>TAVERN</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>JACOB KAUFMAN</b>					14. MOTHER'S MAIDEN NAME <b>RACHEL ?</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>062-01-9816</b>		17. INFORMANT ADDRESS <b>MRS. FANNY KAUFMAN, 3305 MARNAT ROAD #9</b>				
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <b>Intrastatic Carcinoma</b> DUE TO (B) <b>Breast Cancer</b> DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH <b>12 weeks</b> <b>16 weeks</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>April 19 65</b> to <b>September 19 66</b> , that (I) (we) last saw the deceased alive on <b>September 22 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Carl Rudner</b>					M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>9-23-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>CETIC RUDNER</b>					23D. ADDRESS M.D. <b>6821 REISTERSTOWN RD BALTIMORE, MD</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/23/66</b>		24C. NAME of CEMETERY or CREMATORY <b>JEWISH FORBAND</b>		24D. LOCATION <b>BALTIMORE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 20 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</b>			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09647</b>	
BIRTH NO. <b>66 09647</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>DAVID FINIFTER</b>		2. DATE AND HOUR OF DEATH <b>SEPTEMBER 23, 1966</b>   <b>12</b> <sup>30</sup> <b>A.</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BOLTON HILL NURSING HOME</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>22-01</b> D. STREET ADDRESS (If rural, give location) <b>225 S. SHARP STREET</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>DECEMBER 1, 1892</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF-EMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MERCHANT</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>MORTON BENJAMIN FINIFTER</b>		14. MOTHER'S MAIDEN NAME <b>ETHEL LEAH ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>MRS. MILDRED FINIFTER, 225 S. SHARP STREET</b>	
18. <b>332X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <b>Cerebral Thrombosis</b> DUE TO (B) <b>Cerebral arteriosclerosis</b> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>5 years</b>	
19A. DATE OF OPERATION <b>9/23/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>was not present</del> ) attended the deceased from <b>July 25, 1966</b> to <b>Sept 23, 1966</b> , that (I) ( <del>was not</del> ) last saw the deceased alive on <b>September 22, 1966</b> and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was not</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Stanley J. Felzenberg</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9/23/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>STANLEY FELZENBERG</b>		23D. ADDRESS <b>1129 E. BALTIMORE STREET</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/23/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>(ANSHE EMUNAH) - AITZ CHAIM</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>		24E. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>			
25A. NAME OF REGISTRAR <b>SEP 26 1966</b>		25B. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</b>		25C. ADDRESS	



66 09648

BALTIMORE CITY HEALTH DEPARTMENT

66 09648

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Annie Crawford

2. DATE AND HOUR PRONOUNCED DEAD

9/19/66

7:43 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2102 Bolton St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

Feb 2, 1914

52

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Fred Nowwood

14. MOTHER'S MAIDEN NAME

Lula McMillian

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

219-22-0715

17. INFORMANT

ADDRESS

Jerry Nowwood 1800 Elting St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Craniocerebral injury

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

house

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1713 Linden Ave.

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

9 19 66 4:45p.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

fell and struck head

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/20/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Burial

9/23/66

Mt Auburn

Balt

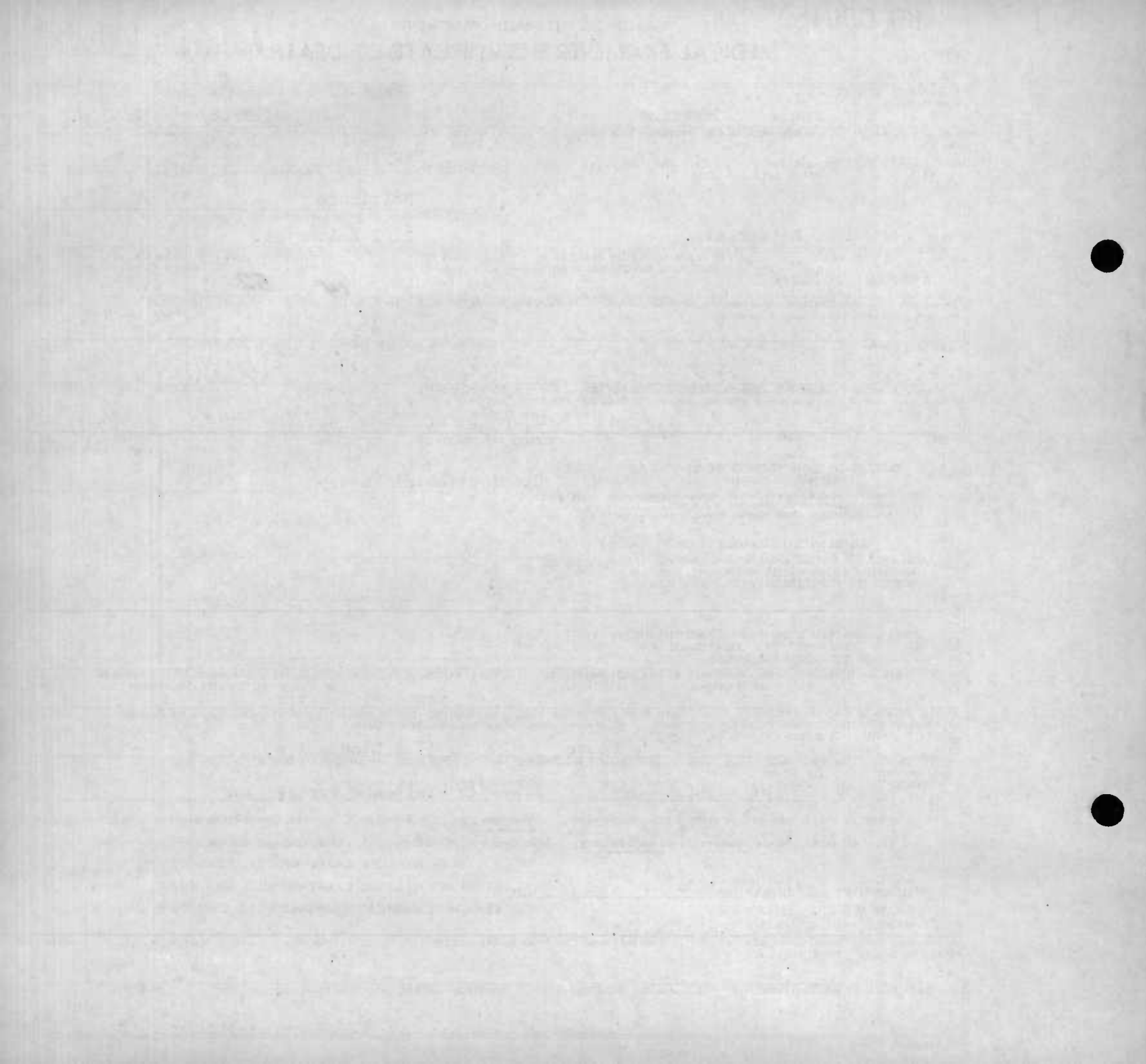
Md

SEP 26 1966

Werner U. Spitz, M.D.

Geo. B. Kelson

13418 N. Calhoun St





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 09649		Registered No. 66 09649	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <b>WEST, CLARENCE</b>				2. DATE AND HOUR OF DEATH <b>9-22-66 10<sup>50</sup> P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSP BALT, MD</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 1303</b>			
				O. STREET ADDRESS (If rural, give location) <b>2613 Pennsylvania Ave #17</b>			
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>9/13/93</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months	If Under 24 Hrs. Ooys	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Howard West</b>				14. MOTHER'S MAIDEN NAME <b>Amelia Payne</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218005-6493</b>		17. INFORMANT <b>Evelyn Robinson</b>		ADDRESS <b>2613 Penna. Ave.</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>cerebral insufficiency</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>				(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>congestive heart failure</b> (B) DUE TO <b>1 month</b>				(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>myocardial infarct</b> (C) DUE TO <b>1 month</b>				(C) DUE TO			
19. DATE OF OPERATION <b>2</b>							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-17-66</b> 19 to <b>9-22</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9-22</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>B. Portnoy</b>						23B. DATE SIGNED <b>9-22-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>B. Portnoy</b>				23D. ADDRESS <b>UNIV. HOSP</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-27-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. Nat'l. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George Kelson 1348 N. Calhoun St.</b>			

10-10-74  
M and L and  
P. J. Jones  
213 Pennsylvania Ave #17  
Phila PA 19103

UNIVERSITY HOSP  
BAPT. MID  
200-2000 C 14

Cardiac insufficiency  
congestive heart failure  
myocardial infarct

YES

9-23-74  
B. Portnoy  
M. Portnoy

1  
W-300

66 09650

BALTIMORE CITY HEALTH DEPARTMENT

66 09650

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas Wade

2. DATE AND HOUR PRONOUNCED DEAD

9/21/66 4:15 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1413 Edmondson Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1413 Edmondson Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

3-23-27

9. AGE (In years last birthday)

39

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Lillian Wade

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

219-28-1600

17. INFORMANT

ADDRESS

Lillian Watkins 1211 Widwood Pkwy.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/22/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9-26-66

23C. NAME OF CEMETERY or CREMATORY

Balto. Nat'l. Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

George G. Kelson 1348 N. Calhoun St.



66 09651

BALTIMORE CITY HEALTH DEPARTMENT

66 09651

BIRTH NO. 66-16233

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ROGER

BENSON

2. DATE AND HOUR PRONOUNCED DEAD

September 24, 1966

7:15 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1023 N. Stricker Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1023 N. Stricker Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Aug 9, 1966

9. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

1-3/4

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Ralf Jones

14. MOTHER'S MAIDEN NAME

Gloria Benson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

1

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Gloria Benson

1023 Stricker St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Interstitial Pneumonitis (SDII)  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Bräitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/24/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9-27-66

23C. NAME of CEMETERY or CREMATORY

Mount Auburn Cem.

23D. LOCATION

Baltimore.

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Morton E. Dyett F.H.

1701 Laurens St.

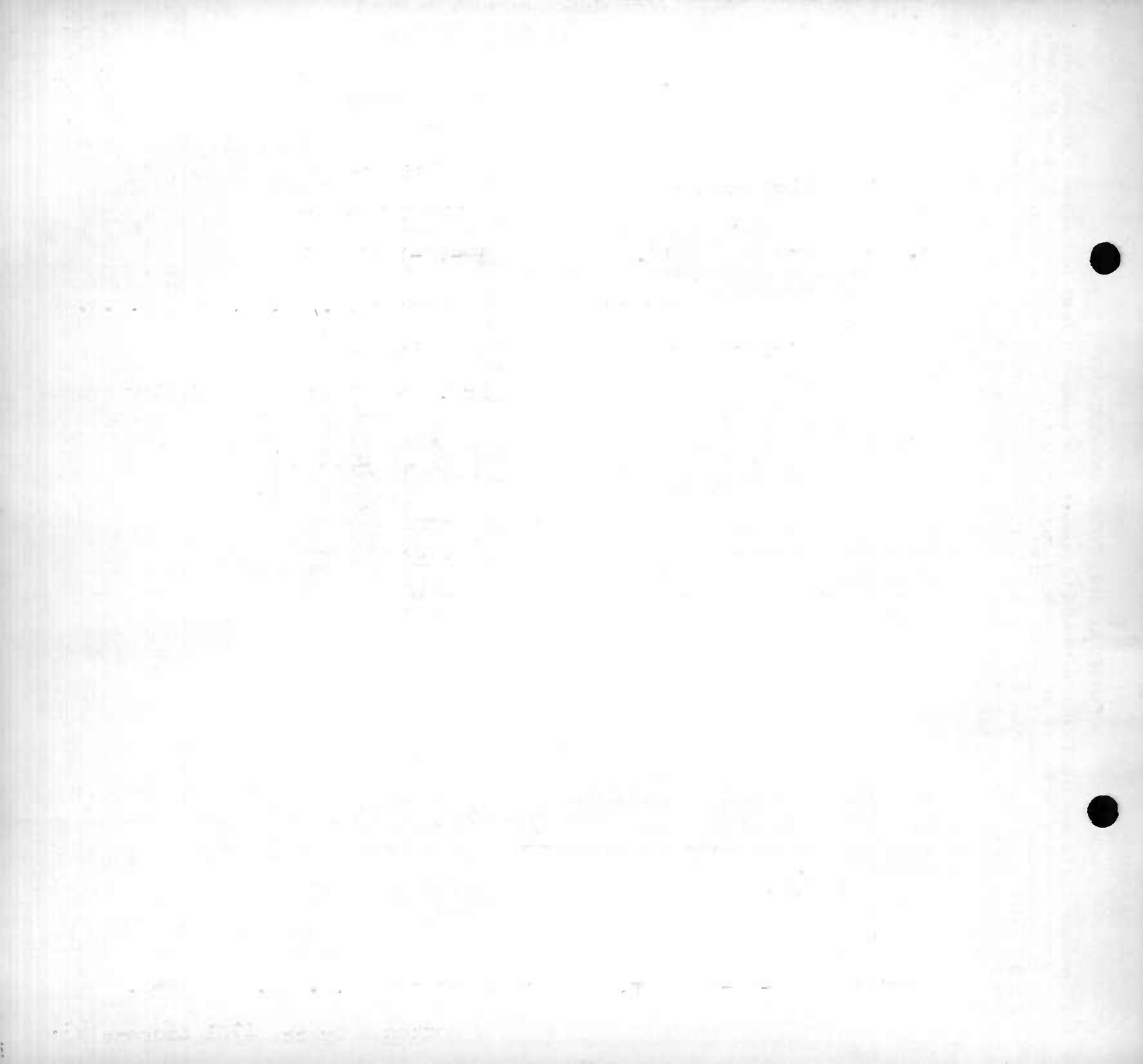
VALLI & FORGE



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 09652	
BIRTH NO. 66 09652		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY E. TINKLER		2. DATE AND HOUR OF DEATH 9-23-66 9 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2314 Callow Avenue				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 2314 Callow Avenue			
5. SEX Fe.	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Wid.	8. DATE OF BIRTH 12-25-1895	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) Chester Co., S. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Payden				14. MOTHER'S MAIDEN NAME Eliza Payden			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Rose Brown 2446 Callow Avenue			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 443X1 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Cerebral Hemorrhage (B) DUE TO Hypertensive Cardiovascular Disease - arteriosclerosis (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug 11 1966 to 9-23-66 that (I) (we) last saw the deceased alive on 9-22-66 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE McDonald Bando M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9-24-66	
23C. PHYSICIAN'S NAME (Type) McDONALD BANDO				23D. ADDRESS M.D. 2456 McCulloh St. BALTIMORE Md 21217			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-26-66		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) A.A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Morton & Dyett		ADDRESS 1701 Laurens St.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO.					66 09653				
M.E. CASE NO.					66 09653				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
MARY CARMELITA WARNER					9/23/66 9 55 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
44 Union Memorial Hospital					Maryland 26-03				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore				
					D. STREET ADDRESS (If rural, give location)				
					3922 Lyndale Ave.				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (in years last birthday)	
Female		White		Widowed		1/8/93		73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY				
None Housewife					Own Home				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
William Fahrman					Margaret Zahner				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					220-30-6148		Patient's Chart		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
260X I					Med. Cardiac Infarction				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO				
					Diabetes Mellitus				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Hyper tension				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <del>9/10</del> 9/10 19 66 to 9/23 19 66, that (I) (we) last saw the deceased alive on 9/23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE								23B. DATE SIGNED	
John R. Vaughan Jr.								9/23/66	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
JOHN R. VAUGHAN, JR.					THE UNION MEMORIAL HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		9-26-1966		Holy Redeemer		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS			
SEP 26 1966			R. E. E. E. E.			Lilly & Zeiler Inc. 1901-07 Eastern Ave.			

8

THE OFFICE OF THE ATTORNEY GENERAL

JOHN W. WOOD, JR.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09654		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09654	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>HARRIETT INA WOLBARSH</b>		2. DATE AND HOUR OF DEATH <b>9/25/1966 1900 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>28-41</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>4308 LIBERTY HEIGHTS AVE</b>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <b>4308 LIBERTY HEIGHTS AVE</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>DIVORCED</b>	8. DATE OF BIRTH <b>JAN 12, 1928</b>	9. AGE (In years last birthday) <b>38</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>JEWELER</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO, MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>SAMUEL</b>		14. MOTHER'S MAIDEN NAME <b>ROSE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-26-3208</b>		17. INFORMANT <b>MOTHER</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>780.21</b>		CAUSE OF DEATH <b>Convulsive disorder, etiology unknown.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>at least 5 years</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>September 19 63</b> to <b>Sept. 25 19 66</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>May 13 19 66</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>Worth B. Daniels, Jr.</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9/26/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Worth B. Daniels, Jr.</b>		23D. ADDRESS M.D. <b>11 E. Chase St. Balto., Md. 21202</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>9/27/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Hebrew Friendship</b>	
24D. LOCATION (City, town, or county) <b>Balto</b>		24E. (State) <b>Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>20248 J. J. J.</b>		25C. FUNERAL DIRECTOR <b>Sylvan S. Lewis, Inc</b>	
25D. ADDRESS <b>3319 Olympic Ave</b>					

RECEIVED

7-10-1914

RECEIVED

7-10-1914

RECEIVED

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M-323  
B-652

66 09655

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09655

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Evelyn BRINKLEY (Midgett)

2. DATE AND HOUR PRONOUNCED DEAD

Sept. 22. 1966

1:55 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1151 Carrollton Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1151 Carrollton Avenue

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

July 15, 1921

9. AGE (In years  
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Ernest Ware

14. MOTHER'S MAIDEN NAME

Pearlie Midgett

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Robert Brinkley 1151 Carrollton Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

II Bronchial Asthma

(A).....  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B).....  
DUE TO

(C).....

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Obesity

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK

NOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

Werner U. Spitz, MD  
EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9. 22. 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9/26/66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 26 1966

24B. NAME OF REGISTRAR

Robert E. Spitz

24C. FUNERAL DIRECTOR

WM C MARCH 928 E North Ave

ADDRESS

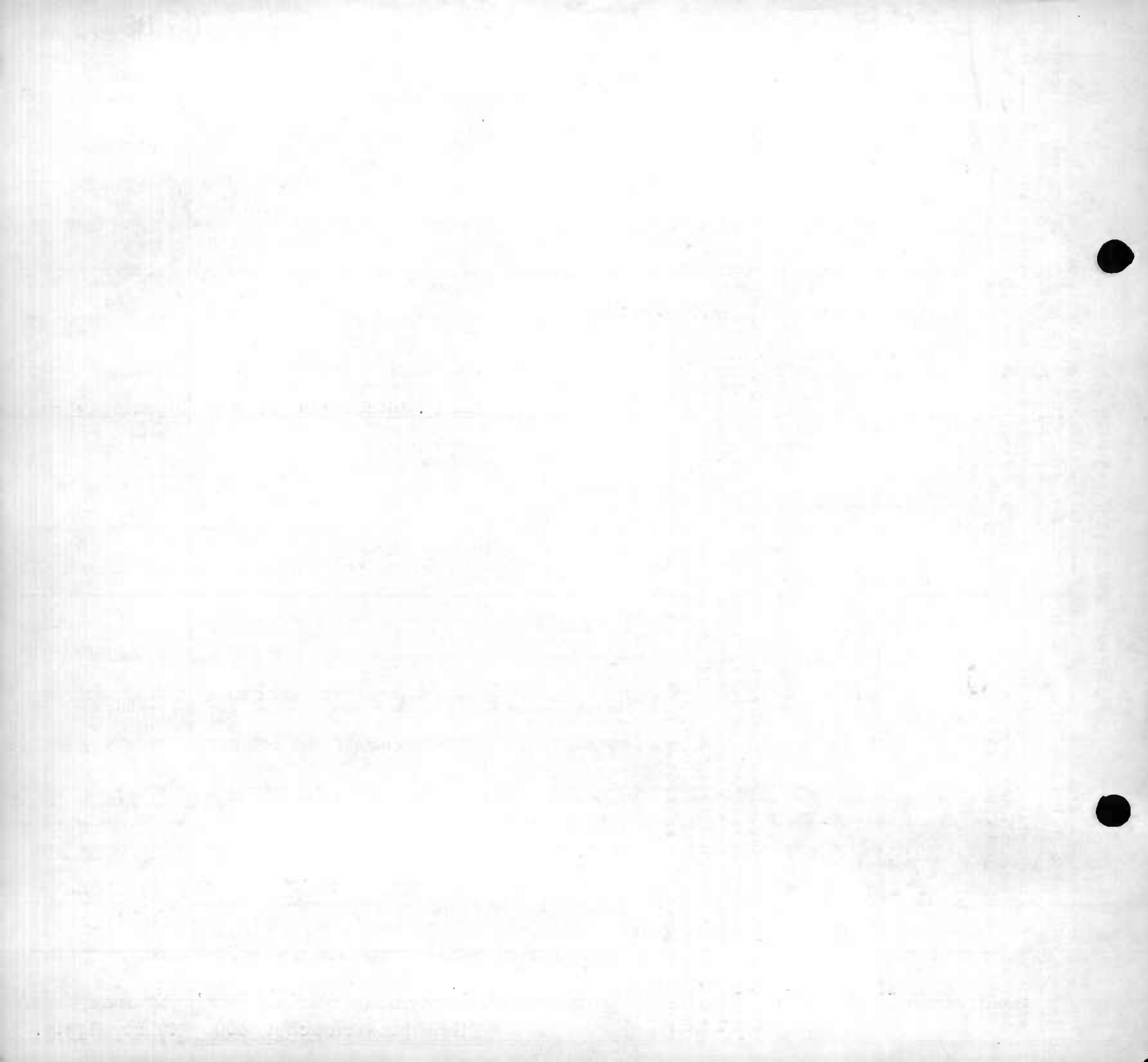
VALLEY PORT



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

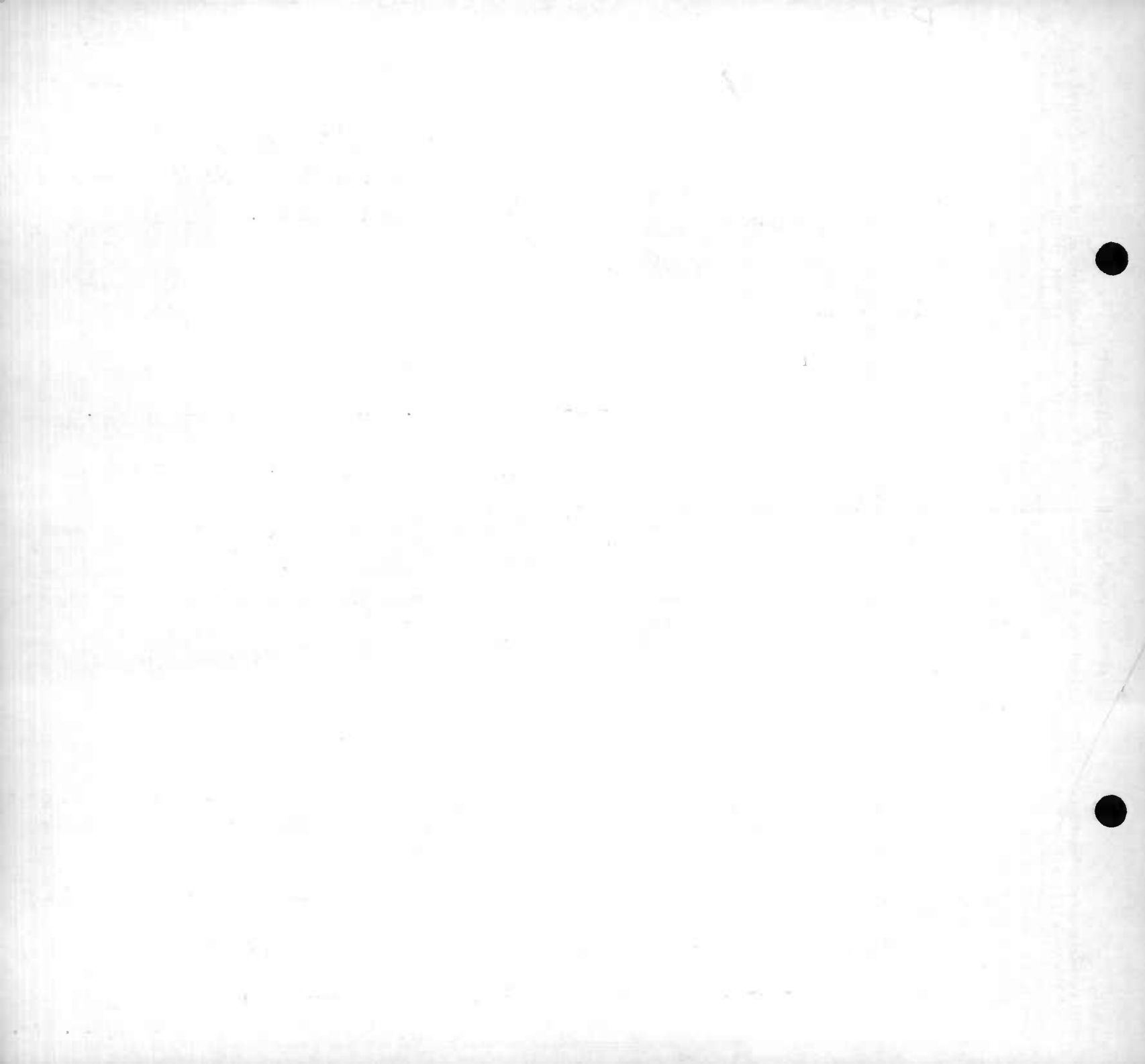
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09656	
BIRTH NO. <b>H 325 66 09656</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <b>Hutchinson, Mr. RENNARD S.</b>		2. DATE AND HOUR OF DEATH <b>24 Sept 1966 10:38 P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>3714 Springdale Ave</b>			
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>MARRIED</b>	8. DATE OF BIRTH <b>8-6-04</b>	9. AGE (In years last birthday) <b>62</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Oscar Hutchinson</b>		14. MOTHER'S MAIDEN NAME <b>Cassie Smith</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>278 055321</b>		17. INFORMANT <b>Ina G. Hutchinson 3714 Springdale Avenue</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Aspiration</b>		CAUSE OF DEATH (A) DUE TO <b>Aspiration</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Laennec's Cirrhosis</b>		(B) DUE TO <b>Vomiting</b>			
(C) DUE TO <b>Laennec's Cirrhosis</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>23 Aug 66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Massive Ascites, ? Ad mass</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>15 Aug 1966</b> to <b>24 Aug 1966</b> and that in (my) (our) opinion death occurred on the date <b>24 Aug 1966</b> and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edward D. Layne</b>				23B. DATE SIGNED <b>24 Sept 66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Edward D. LAYNE</b>		23D. ADDRESS <b>Maryland General Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-28-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Wheelersburg Cemetery</b>	
24D. LOCATION <b>Wheelersburg, Ohio</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>			
25B. NAME OF REGISTRAR <b>Ellsworth Armbrust</b>		25C. FUNERAL DIRECTOR <b>Ellsworth Armbrust 4600 Liberty Hgts.</b>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09657</u>	
BIRTH NO. <u>P 360</u>		66 09657		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Potter, Dorothy</u>		2. DATE AND HOUR OF DEATH <u>Sept. 23, 1966 5:26 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>4415 Marble Hall Rd.</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-09</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Baltimore</u>		D. STREET ADDRESS (If rural, give location) <u>4415 Marble Hall Rd.</u>			
5. SEX <u>Fe.</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>7/18/98</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleswoman</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Almon Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Lulu Ames</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-30-4265</u>		17. INFORMANT <u>Hugh M. Potter 4415 Marble Hall Rd.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>		CAUSE OF DEATH (A) DUE TO <u>Arteriosclerotic heart disease</u> (B) DUE TO <u>years</u> (C) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>① Rheumatic valvular disease</u> <u>② Non toxic Goiter.</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 23</u> 19 <u>66</u> to <u>Sept. 23</u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>Sept. 23</u> 19 <u>66</u> and that in (my) (our) apinian death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Erwin H. Hesselberg</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Sept. 23, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Erwin H. Hesselberg</u>		23D. ADDRESS <u>Sinai Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-26-66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Ellsworth Anacost</u>	
				ADDRESS <u>4600 Liberty Hghts. Ave.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09658	
BIRTH NO. <b>1K314 66 09658</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Anna Kimb. ll</b>		2. DATE AND HOUR OF DEATH <b>Sept 25, 1966 6<sup>35</sup> P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>South Baltimore General Hosp</b>		A. STATE <b>MD</b> B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO 23-01</b>			
		D. STREET ADDRESS (If rural, give location) <b>135 W. CLAREMONT ST CLAREMONT</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, <u>DIVORCED</u> (specify)		8. DATE OF BIRTH <b>11-25-95</b>	9. AGE (In years last birthday) <b>70</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Russia Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Max Miller</b>			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Anna Kimb. ll</b>		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b>		CAUSE OF DEATH (A) <b>Uremia</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>4 wks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Cancer of Endometrium</b> DUE TO		<b>4 yrs.</b>	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Diabetes Mellitus</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 3 1966</b> to <b>Sept. 25 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept. 25 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Albert T. Miller</b>				23B. DATE SIGNED <b>9/25/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Albert T. Miller</b>				23D. ADDRESS <b>South Balt. Gen. Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/27/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Anshe Emunah City Charn Balto</b>	
24D. LOCATION (City, town, or county) (State) <b>MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>			
25B. NAME OF REGISTRAR <b>John E. Smith, M.D.</b>		25C. FUNERAL DIRECTOR <b>Sylvan S. Lewis &amp; Son 3319</b>			
25D. ADDRESS <b>Olympia Ave</b>					

Q/H

1st of January - 1st of January

2nd of January - 2nd of January

3rd of January - 3rd of January

4th of January - 4th of January

5th of January - 5th of January

6th of January - 6th of January

7th of January - 7th of January

8th of January - 8th of January

9th of January - 9th of January

10th of January - 10th of January

11th

12th

13th of January - 13th of January

14th of January - 14th of January

15th of January - 15th of January

16th of January - 16th of January

17th of January - 17th of January

18th of January - 18th of January

19th of January - 19th of January

20th of January - 20th of January

21st of January - 21st of January

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09659</b>	
BIRTH NO. <b>88 09659</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>9/22/66 9:20 P. M.</b>	
1. NAME OF DECEASED (Type or Print) <b>KATHLEEN WRIGHT</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital BALTIMORE, MD 21205</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>ROXTON</b>	
		D. STREET ADDRESS (If rural, give location) <b>1410 BOYCE AVE</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>5-13-82</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	9. AGE (In years lost birthday) <b>84</b>
13. FATHER'S NAME <b>Frederick WRIGHT</b>		11. BIRTHPLACE (State or foreign country) <b>SPRINGBORO, OHIO</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>SARAH BRUEN</b>	
17. INFORMANT <b>MISS ALICE WRIGHT</b>		ADDRESS <b>(SAME)</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 HOURS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>CORONARY ARTERIOSCLEROSIS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>14 SEPT 66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>TRIGEMINAL NEURALGIA</b>	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>13 SEPT 19 66</b> to <b>22 SEPT 19 66</b> , that (I) (we) last saw the deceased alive on <b>22 SEPT 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Mewyn Bagan</b> M.D.		23B. DATE SIGNED <b>22 SEPT 66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MERYN BAGAN</b> M.D.		23D. ADDRESS <b>Johns Hopkins Hospital, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>	24B. DATE <b>9/24/1966</b>	24C. NAME of CEMETERY or CREMATORY <b>Greenmount</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>	25B. NAME OF REGISTRAR <b>R. E. B. J. B. M.</b>	25C. FUNERAL DIRECTOR ADDRESS <b>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>	

1952-1953

John Edgar Wright  
Baltimore, Md

W  
NEVER MARRIED

Highland  
Baltimore  
1410 Dejeu Ave

2-13-85

Frederick Wright

2100 N. E. St

also known as Wright

incidental information

CONCERNING INTERESTS

14 SEPT 1952  
NO

13 SEPT 1952

22 SEPT 1952

22 SEPT 1952

Oliver Wright

X

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 09660</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>66 09660</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>William J. Wright</b>			2. DATE AND HOUR OF DEATH <b>September 24, 1966 130 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital</b>			4. USUAL RESIDENCE (Where deceased lived; If institution, residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1515 Pentridge Rd</b>		
5. SEX <b>Male</b>	6. RACE <b>Cauc.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	B. DATE OF BIRTH <b>1/27/01</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Workshop for Blind - Retired - Vendor</b>		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William J. Wright</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth White</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-05-1320</b>	17. INFORMANT <b>REGINA B. WRIGHT</b> <b>Wife</b> ADDRESS <b>1515 Pentridge Rd Balto, Md.</b>		
18. <b>181.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Urinary Bladder</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>Pneumonitis</b> DUE TO		
			(C) <b>Urinary Tract Infection</b> DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b> <b>Congestive Heart Failure</b>			<b>1 month</b>		
19A. DATE OF OPERATION <b>9-16-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CA of Bladder - Unilateral Dist.</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (APPROX.) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> — Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>8-5</b> 19 <b>66</b> to <b>9-24</b> 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>9-24</b> 19 <b>66</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Ralph M Howard</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9-24-66</b>
23C. PHYSICIAN'S NAME (Type) <b>Ralph M Howard</b>			23D. ADDRESS M.D. <b>Dept of Urology University Hospital Balto. Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9/28/1966</b>	24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>R. E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd Balto. 12, Md.</b>	

9. 2011 2011-2012

10. 2011 2011-2012

11. 2011 2011-2012

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13. 2011 2011-2012

14. 2011 2011-2012

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17. 2011 2011-2012

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39. 2011 2011-2012

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41. 2011 2011-2012

42. 2011 2011-2012

43. 2011 2011-2012

44. 2011 2011-2012

45. 2011 2011-2012

46. 2011 2011-2012



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

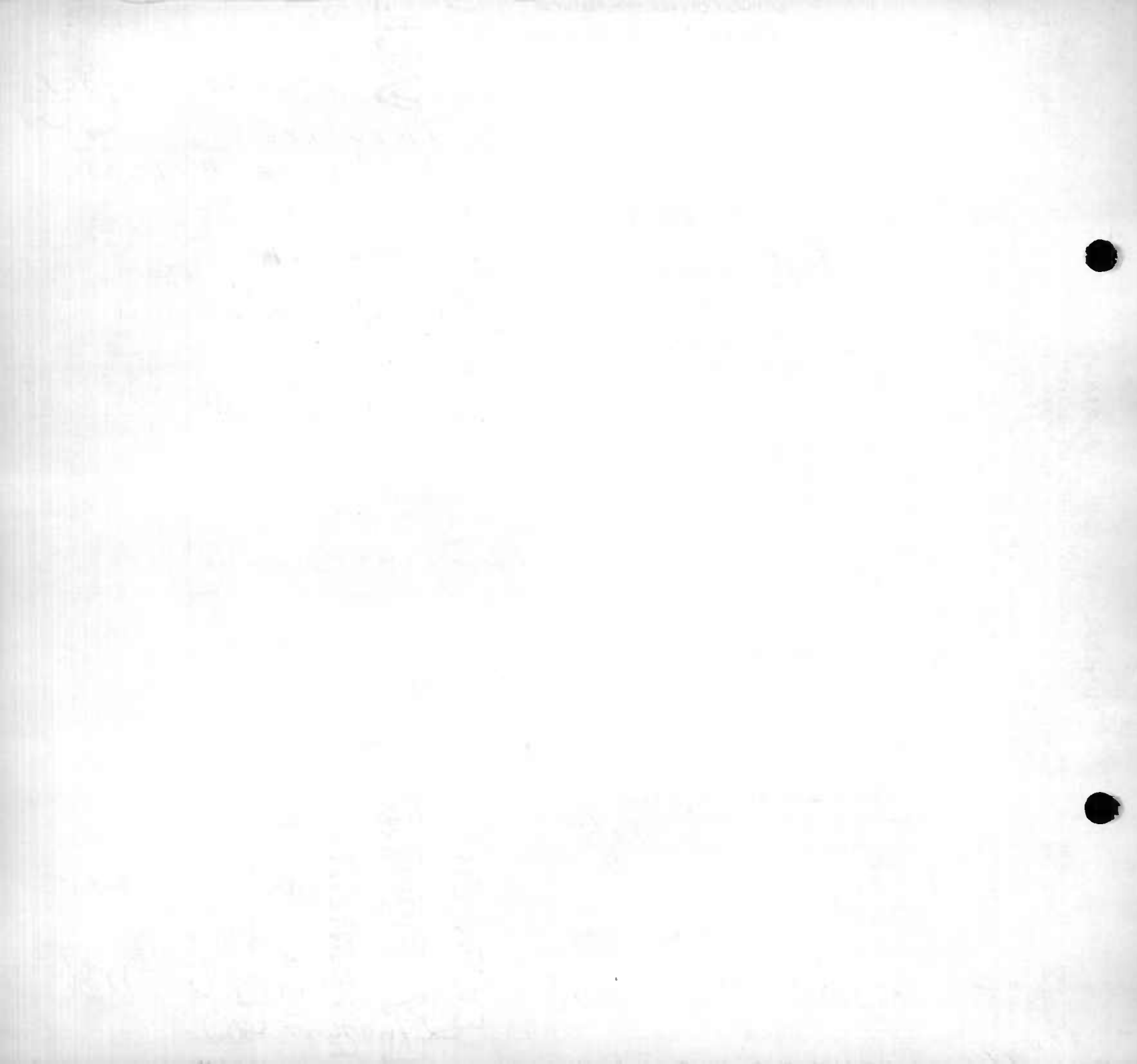
BIRTH NO. <u>66 09661</u>		Baltimore City Health Department		Registered No. <u>66 09661</u>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <u>THERESA KAREN WINTERS</u>			2. DATE AND HOUR OF DEATH <u>Sept. 20, 1966</u> <u>3:49</u> P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>md. GEN. Hosp.</u>			A. STATE <u>md.</u> B. COUNTY <u>11-03</u>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO #1</u>		
			D. STREET ADDRESS (If rural, give location) <u>827 N Eutaw St.</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>N.B.</u>	8. DATE OF BIRTH <u>Sept. 19, 1966</u>	9. AGE (In years last birthday) <u>1</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <u>1</u> <u>9</u> <u>9</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
13. FATHER'S NAME <u>J. R. WINTERS</u>		14. MOTHER'S MAIDEN NAME <u>THERESA MYRTLE GUNZA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>MOTHER</u> <u>SAME</u>	
18. <u>762.5</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Immaturity &amp; anoxia</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 19</u> 19 <u>66</u> to <u>Sept 20</u> 19 <u>66</u> , that (I) <u>we</u> last saw the deceased alive on <u>Sept 20</u> 19 <u>66</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I) (We) (did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Bernard Dick</u>				23B. DATE SIGNED <u>9/20/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Bernard Dick</u>				23D. ADDRESS <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
24A. BURIAL CREMATION REMOVAL (Specify) <u>SEP 26 1966</u>		24B. DATE <u>SEP 26 1966</u>		24C. NAME OF CEMETERY OR CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
24D. LOCATION (City, town, or county) (State) <u>MORTUARY SERVICE - BMD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1966</u>		25B. NAME OF REGISTRAR <u>SEP 26 1966</u>	
25C. FUNERAL DIRECTOR ADDRESS					

Travels of J. J. Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 09662</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09662</b>	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>John Kelly</b>		
2. DATE AND HOUR OF DEATH <b>9-18-66 3:30 P.M.</b>			3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>South Baltimore General Hosp.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>23-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #2/230.</b> D. STREET ADDRESS (If rural, give location) <b>1009 Peach St.</b>		
5. SEX <b>M.</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>6/1/1905</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Lakewood S.C.</b>	
13. FATHER'S NAME <b>James Kelly</b>			14. MOTHER'S MAIDEN NAME <b>Grace</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Rebecca Mitchell</b>
18. <b>307X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>Septicemia</b> DUE TO (B) <b>Chronic Brain xnd</b> DUE TO (C) <b>dehydration 2° to diarrhea, anemia, et al.</b> <b>unk. carcinoma?</b>		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>9-18-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No.</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>9-17-66</b> to <b>9-18-66</b> , that (we) lost saw the deceased alive on <b>9-18-66</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. G. Arellano</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9-19-66</b>
23C. PHYSICIAN'S NAME (Type) <b>Roberto G. Arellano</b>			23D. ADDRESS <b>South Balt. Gen. Hosp.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-24-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mount Calvary</b>	
24D. LOCATION (City, town, or county) (State) <b>Arundel Co. Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>			
25B. NAME OF REGISTRAR <b>S. L. Brown</b>		25C. FUNERAL DIRECTOR <b>S. L. Brown</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 09663					CERTIFICATE OF DEATH					Registered No. 66 09663				
M.E. CASE NO.					1. NAME OF DECEASED					2. DATE AND HOUR OF DEATH				
(Type or Print)					Frank J. Muscalli					Sept. 25th. 1966 M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION					(If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
566 Lucia Ave										566 Lucia Ave. 25-31				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)										D. STREET ADDRESS (If rural, give location)				
Baltimore										566 Lucia Ave.				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years lost birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
Male		White		Married		Feb. 5, 1922		44						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)				
Ga Guard										Baltimore Md.				
12. CITIZEN OF WHAT COUNTRY?										13. FATHER'S NAME				
										Guido Muscalli				
14. MOTHER'S MAIDEN NAME										15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
Madlina DiSyves tira														
16. SOCIAL SECURITY NO.										17. INFORMANT ADDRESS				
216-12-5152										Dorothy Muscalli 566 Lucia Ave. 29				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)										(A) DUE TO				
ANTECEDENT CAUSES										(B) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(C)				
II										OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
June 28, 1966					Brain Tumor									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED					21F. HOW DID INJURY OCCUR?				
					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from June 28 1966 to Sept 25 1966, that (I) (we) last saw the deceased alive on Sept 21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE										23B. DATE SIGNED				
Barry Pass										4-26-66				
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS				
J. EARL PASS										4001 Withers Ave				
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE					24C. NAME OF CEMETERY or CREMATORY				
Burial					Sept. 28, 1966					Loudon Park Cem.				
24D. LOCATION (City, town, or county)					24E. LOCATION (State)					25A. DATE REC'D BY HEALTH DEPT.				
Balto. Md.										SEP 26 1966				
25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR					25D. ADDRESS				
Philip H. H. H. H.					Philip H. H. H. H.					2024 Orleans St.				

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09664		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09664	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ANTHONY J. DIETZ SR.		September 25, 1966		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Gould Nursing Home		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Edgemere, Baltimore County		5300	
		D. STREET ADDRESS (If rural, give location)			
		Box 254, North Point Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days Hours Min.
Male	White	Widower	Jan. 21, 1902	64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laboratory		Pemco Corp.		Baltimore, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Dietz		Elizabeth Hartman		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Mrs. Margaret DiNatale 3025 Chesterfield Ave	
18. 52301		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) SILENOSIS + PNEUMONITIS.		5 YRS.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CORONARY THROMBOSIS.		SUDAKN.	
		(C) GEN. ARTERIOSCLEROSIS		5 YRS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		NONE			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
NONE				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9-25-66 to 9-25-66 that (I) (we) last saw the deceased alive on 9-25-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Lilly & Zeiler				9/26/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ALBERT R. WILKINSON		1200 ST. PAUL ST - BALTO - 21202 (M)			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-28-1966		Sacred Heart	
				Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 26 1966		Robert E. Zeiler		Lilly & Zeiler Inc. 1901-07 Eastern Ave.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 09665	
CERTIFICATE OF DEATH					
BIRTH NO. 66 09665		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>HELEN Wendorff</b>		2. DATE AND HOUR OF DEATH <b>9/22/66 10<sup>20</sup> A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>Mercy Hospital Baltimore</b> <small>(If not in hospital or institution, give street address or location)</small>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	
8. DATE OF BIRTH <b>9/15/1900</b>		9. AGE (In years, last birthday) <b>66</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. BIRTHPLACE (State or foreign country) <b>MICHIGAN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Oliver Roy</b>	
14. MOTHER'S MAIDEN NAME <b>ANNA HOLLAND</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>452-40-5297</b>	
17. INFORMANT <b>MRS. DOROTHY YORK</b>		18. ADDRESS <b>320 Kennerly Rd Springfield, Penna</b>		19. CAUSE OF DEATH <b>Chronic Bronchitis &amp; Asthma</b> <b>Pulmonary Emphysema</b>	
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		22. INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>10 yrs</b>	
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No)	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
30. TIME OF INJURY (APPROX.)		31. INJURY OCCURRED		32. HOW DID INJURY OCCUR?	
33. I certify that (I) (this hospital) attended the deceased from <b>9/15/66</b> to <b>9/22/66</b> , that (I) (we) last saw the deceased alive on <b>9/22/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		34. SIGNATURE <b>Michael Prokoff</b>		35. DATE SIGNED <b>9/22/66</b>	
36. PHYSICIAN'S NAME (Type) <b>Michael Prokoff</b>		37. ADDRESS <b>Mercy Hospital</b>		38. DATE <b>9-26-66</b>	
39. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		40. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		41. LOCATION (City, town, or county) (State) <b>Baltimore MD</b>	
42. DATE REC'D BY HEALTH DEPT.		43. NAME OF REGISTRAR		44. FUNERAL DIRECTOR <b>W. Cook-Brooks</b>	
45. ADDRESS <b>1217 St. Paul St Baltimore, MD</b>		46. ADDRESS <b>1217 St. Paul St Baltimore, MD</b>			



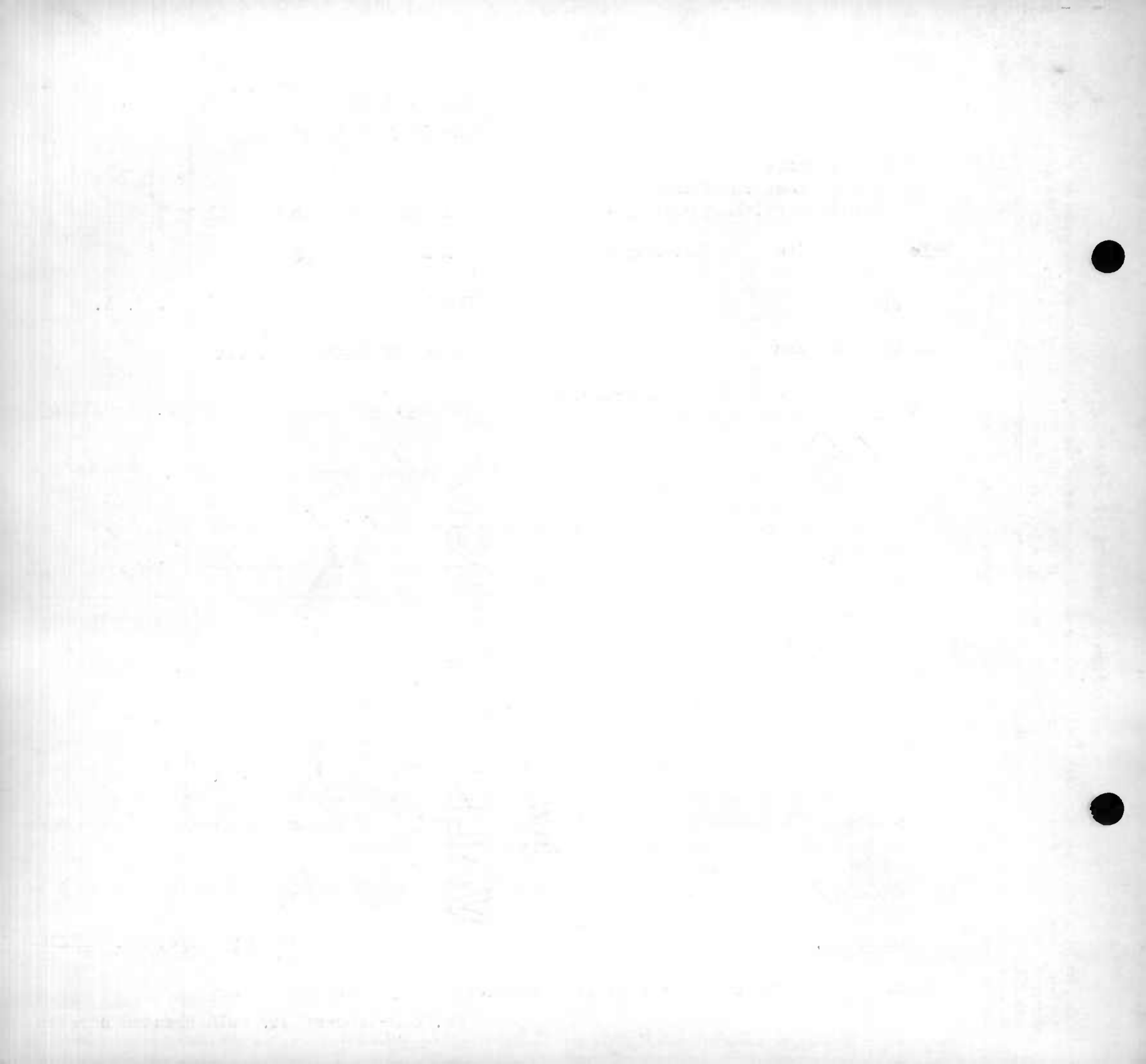
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) <i>Kenneth Mc Cann</i>		2. DATE AND HOUR OF DEATH <i>9-24-66</i> <i>9:46 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>53-00</i> D. STREET ADDRESS (If rural, give location) <i>7715 Fairgreen Road</i> <i>21222</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Never married</i>	8. DATE OF BIRTH <i>12-8-1925</i>
9. AGE (In years last birthday) <i>40</i>		10. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Walter Mc Cann</i>		14. MOTHER'S MAIDEN NAME <i>Viola Cornwell</i> Street	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-22-7095</i>	
17. INFORMANT <i>RECORDS: BCH</i>		ADDRESS <i>4940 Eastern Avenue 21224</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Chronic Renal Failure</i> <i>Chronic Embolism</i>		20. DUE TO <i>1 yr.</i> <i>4 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21C. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21E. TIME OF INJURY (Approx.)		21F. HOW DID INJURY OCCUR?	
21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21H. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21I. DATE OF OPERATION		21J. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21K. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21L. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21M. TIME OF INJURY (Approx.)		21N. HOW DID INJURY OCCUR?	
21O. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21P. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (this hospital) attended the deceased from <i>9-12</i> <i>19 66</i> to <i>9-24</i> <i>19 66</i> , that (we) last saw the deceased alive on <i>9-24</i> <i>19 66</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) <i>view</i> the body after death.		23A. SIGNATURE <i>Richard L. Bishop</i>	
23B. DATE SIGNED <i>9-24-66</i>		23C. PHYSICIAN'S NAME (Type) <i>Richard L. Bishop</i>	
23D. ADDRESS <i>4940 Eastern Avenue Baltimore, Md. 21224</i>		23E. DATE SIGNED <i>9-24-66</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/27/66</i>	
24C. NAME of CEMETERY or CREMATORY <i>Lorraine Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Wm. Cook-Brooks</i>	
25C. FUNERAL DIRECTOR <i>St. Paul &amp; Preston Streets</i>		25D. ADDRESS <i>St. Paul &amp; Preston Streets</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



66 09667

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09667

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM

GILBERT Jr.

2. DATE AND HOUR PRONOUNCED DEAD

September 21, 1966

12:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

415 E. Chase Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

December 1, 1900

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Checker Cloak room

10B. KIND OF BUSINESS OR INDUSTRY

Merchant's Club

11. BIRTHPLACE (State or foreign country)

Washington D.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Gilbert Sr.

14. MOTHER'S MAIDEN NAME

Jennie Brooks

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

214-01-5372

17. INFORMANT

ADDRESS

Mrs. Lillian Morris-3404 Walbrook Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular  
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/21/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9/23/66

23C. NAME of CEMETERY or CREMATORY

Mount Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

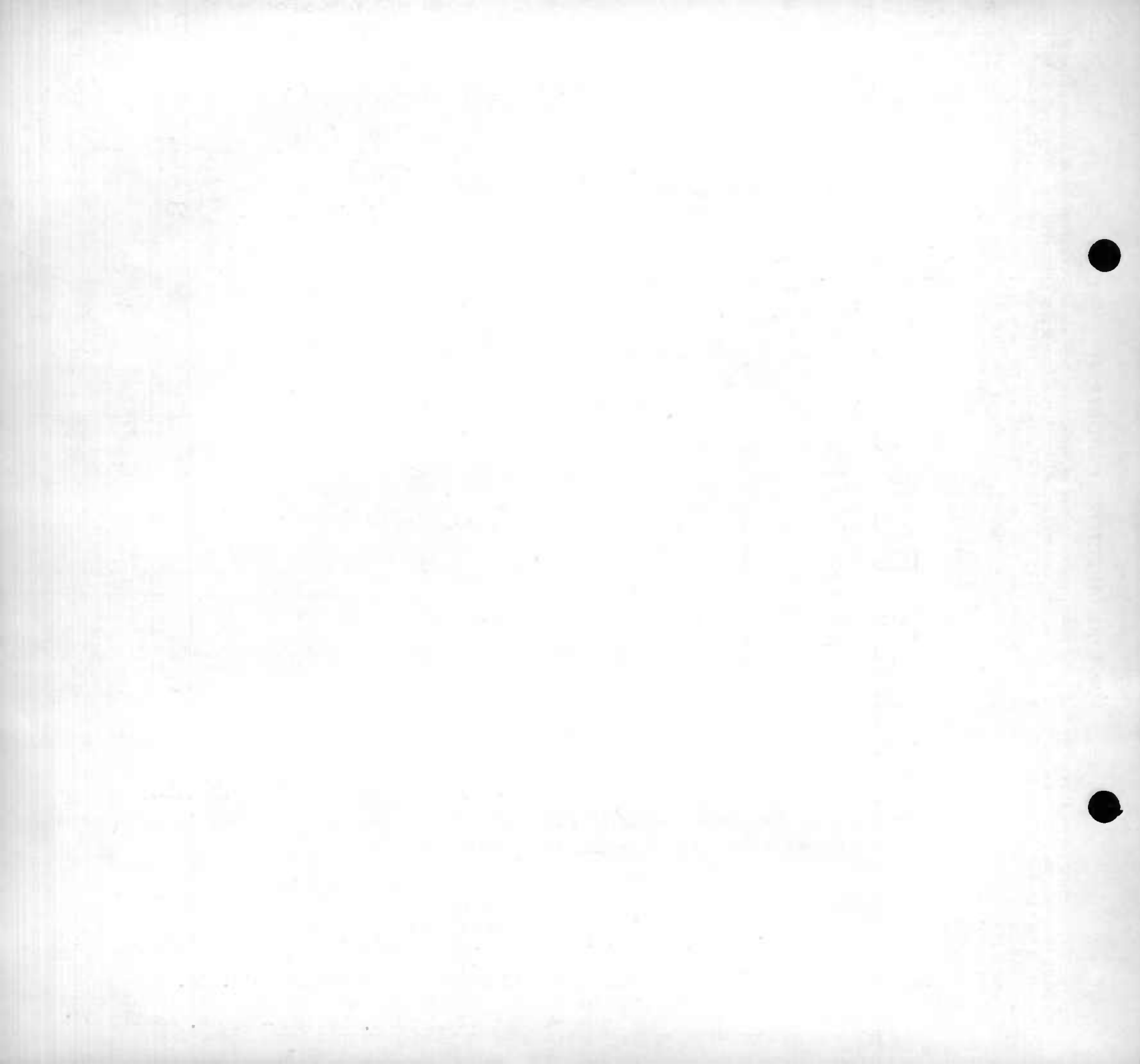
Herbert E. Nutter-3035 W. North Ave.

WALLEY  
FOOTAGE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 096688		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 096688	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Mathias, William Henry</i>		2. DATE AND HOUR OF DEATH <i>9/19/66</i> <i>9:40 P. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>91 Montebello State Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>20-01</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>306 H. Monroe St.</i>			
5. SEX <i>male</i>	6. RACE <i>negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>Dec. 23, 1901</i>	9. AGE (In years last birthday) <i>64</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William H. Mathias</i>		14. MOTHER'S MAIDEN NAME <i>Metcha Johnson</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>217-09-1490</i>		17. INFORMANT ADDRESS <i>Hospital Records</i>	
18. <i>476X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>plemia</i> DUE TO (B) <i>arteriosclerotic nephropathy many years</i> DUE TO (C) <i>gen. arteriosclerosis</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> <i>do.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>no</i>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9/10/66</i> 19 to <i>9/19/66</i> 19, that (I) (we) lost saw the deceased alive on <i>9/19/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <i>Daniel G. Lai</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9/16/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>DANIEL G. LAI</i>		23D. ADDRESS <i>2201 Argonne Drive, Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/24/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Memorial Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Co. Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 26 1966</i>		25B. NAME OF REGISTRAR <i>Robt E. Nutter</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Herbert E. Nutter -3035 W. North Ave.</i>	

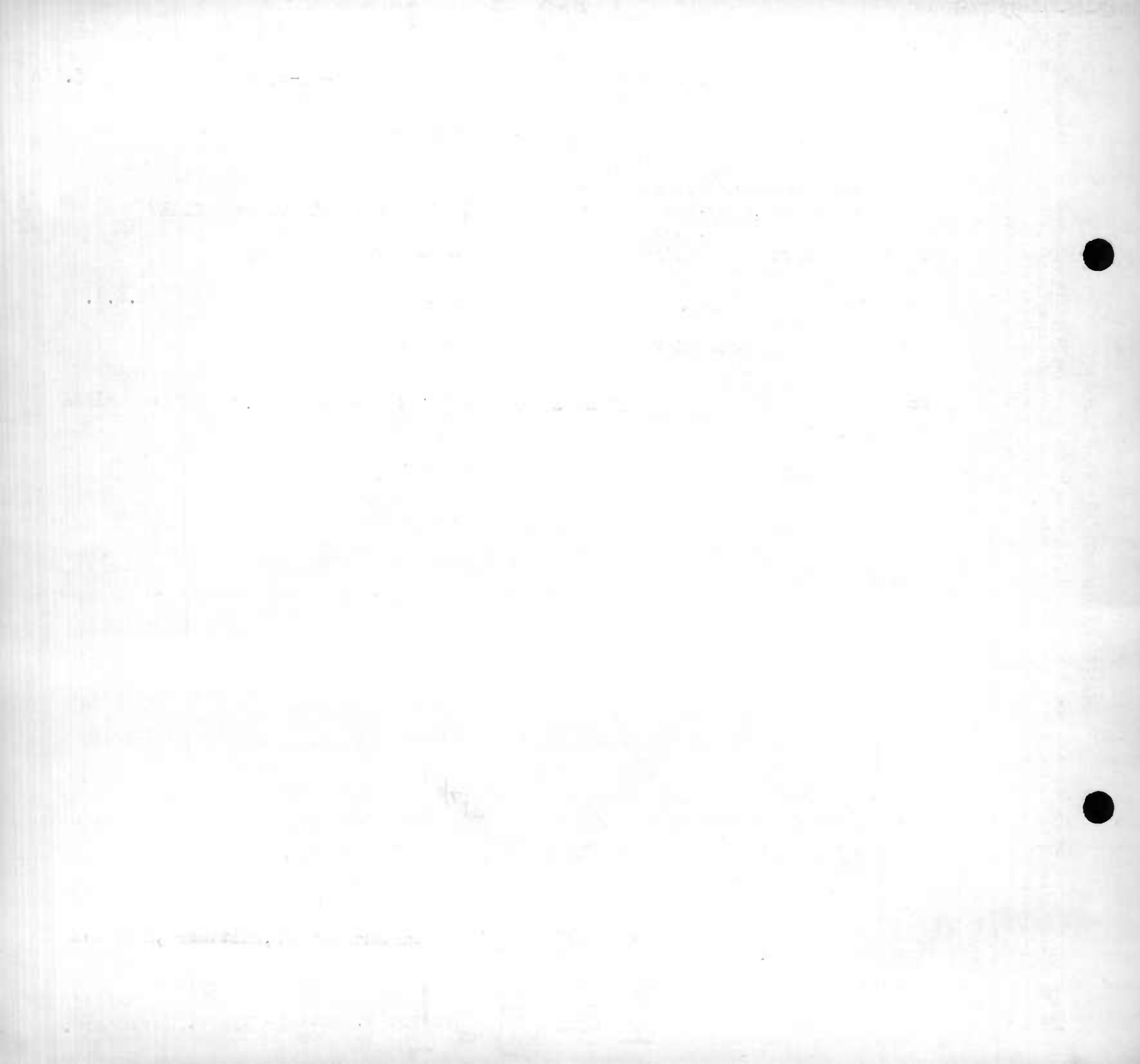






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BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09669	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		5.00A M.	
Mamie Toomer		9-25-1966			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		2304 Edgemont Avenue 21217			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	Negro	Widowed	1-17-1887	79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Domestic		Pvt. Family		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles Alexander Samuel Ford			Alethia Allen		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-36-7964		Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		6 mos.	
ANTECEDENT CAUSES		(B) DUE TO		many years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		many years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/24/66 to 9/25/66, that (I) (we) last saw the deceased alive on 9/24/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Edith Toomer				9/25/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
D. David Swimmer		4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/29/66		Baltimore National Cemetery Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 26 1966		Herbert E. Nutter-3035 W. North Ave.			



S120

68 09670

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 68 09670

BIRTH NO.

M.E. CASE NO.

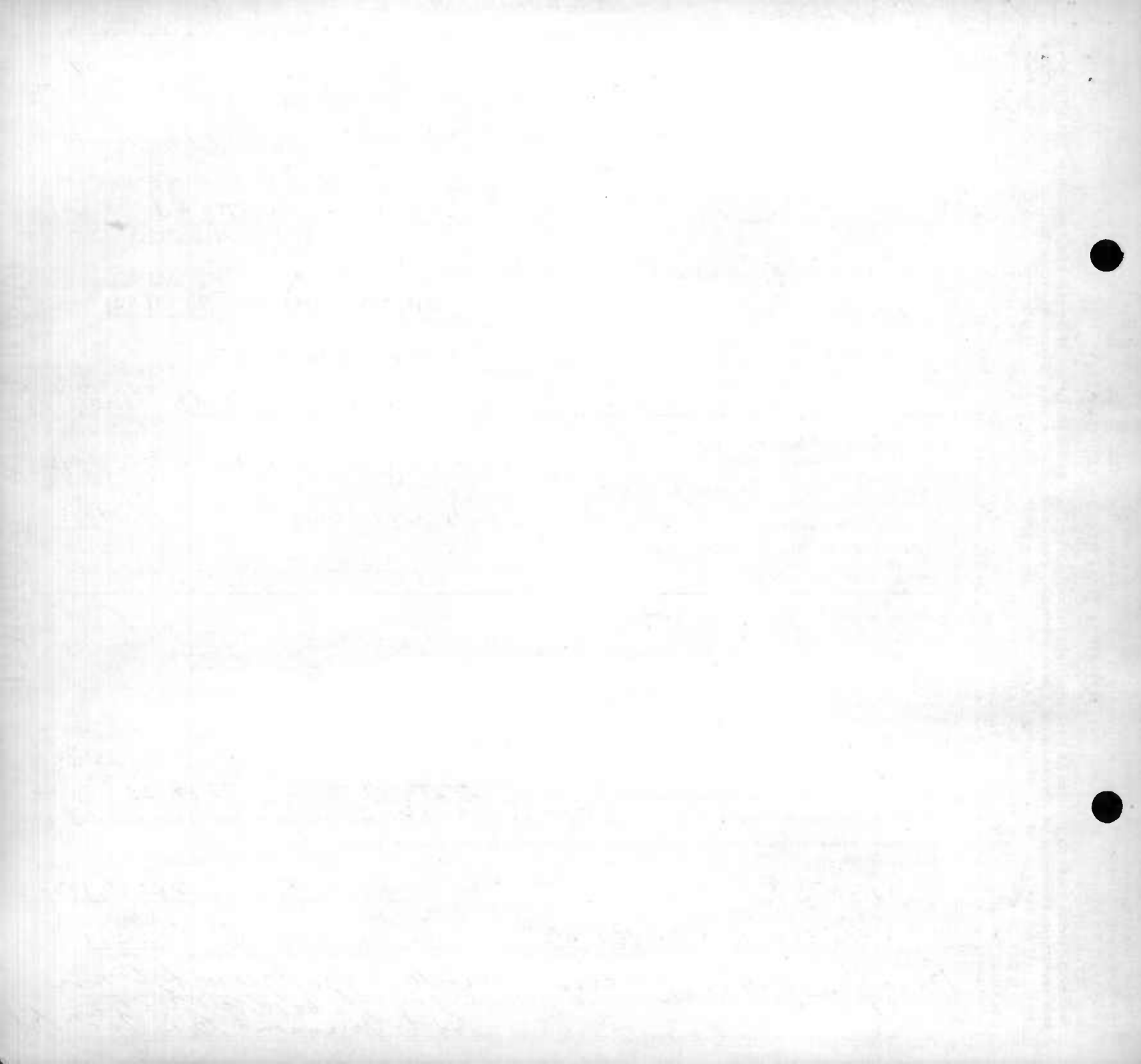
1. NAME OF DECEASED (Type or Print) <b>BENJAMIN SAVAGE</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>September 23, 1966 2:15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-32</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3607 Springdale Avenue</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>April 10, 1905</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	9. AGE (In years last birthday) <b>61</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Savage</b>		14. MOTHER'S MAIDEN NAME <b>Lena Cohen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-07-5114</b>	17. INFORMANT ADDRESS <b>Mr. Louis Savage 3732 Offutt Road</b>
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Massive Pulmonary Embolism</b> DUE TO II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>9/25/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Rudiger Breitenecker</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>9/25/1966</b>	23C. NAME OF CEMETERY or CREMATORY <b>Bnai Israel</b>
24A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		24B. NAME OF REGISTRAR <b>Sol Levinson &amp; Bros.</b>	24C. FUNERAL DIRECTOR ADDRESS <b>6010 Reisterstown Rd.</b>
23D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

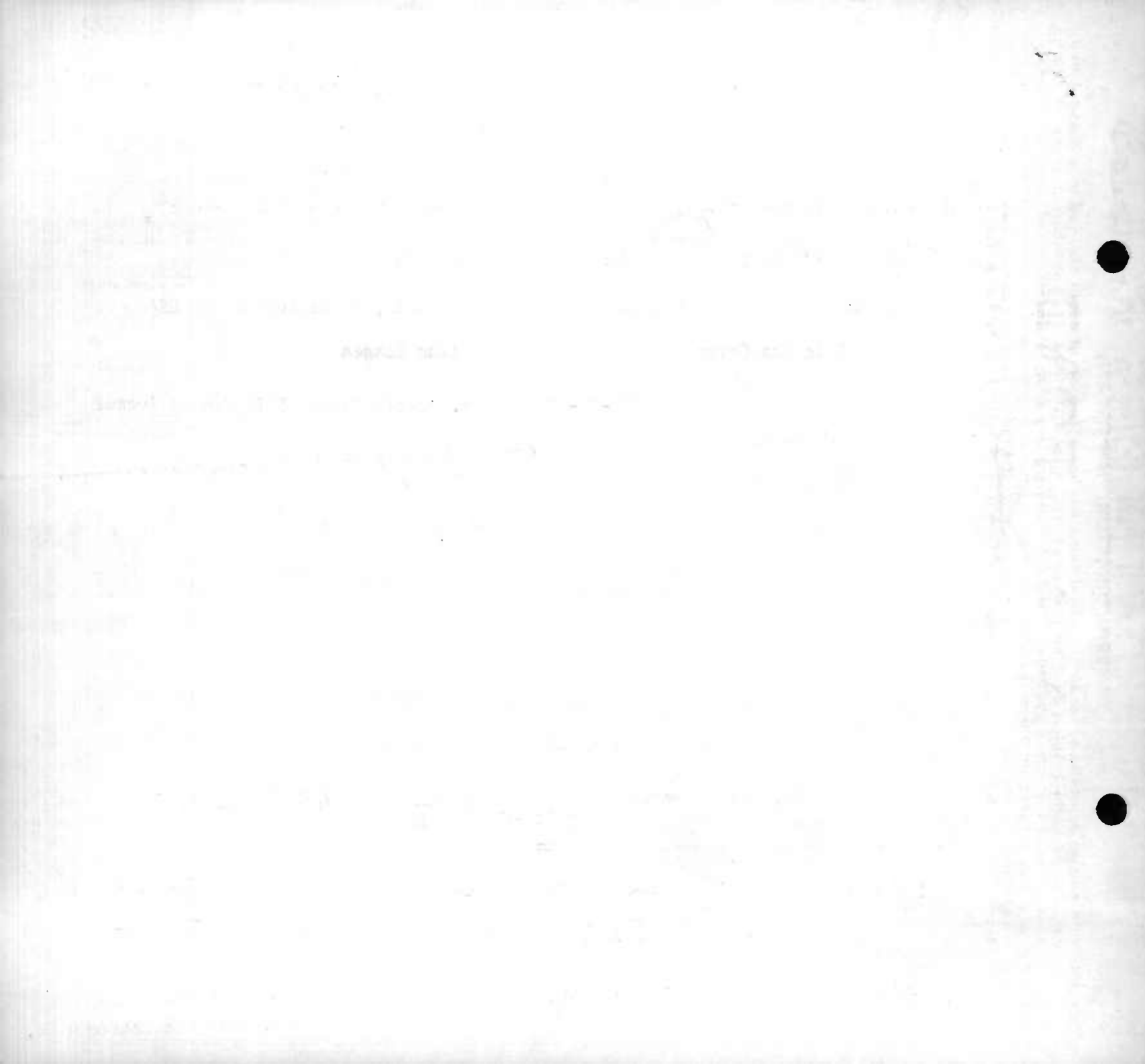
BIRTH NO. 65 12879		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09671	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DAVID SCOTT PESSIN		2. DATE AND HOUR OF DEATH SEPT 23, 1966 4 <sup>07</sup> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL. LOMBARD + GREENE STS. BALTO., MD. 21201		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY HOUNS C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLIOTT CITY. 6300 D. STREET ADDRESS (If rural, give location) 349 HIGH POINT RD.			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH MAY 23, 1965	9. AGE (In years last birthday) 1	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) BALTO., MD.	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME JACQUES PESSIN		14. MOTHER'S MAIDEN NAME RUTH BARNETT.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT KENNETH R. KOSKINEN M.D.	
18. 355-X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (L) SIDED PNEUMONIA.		CAUSE OF DEATH (A) cerebral + myocardial anoxia DUE TO (B) febrile convulsion DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 days 3 1/2 days	
19A. DATE OF OPERATION O NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) NONE		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPT 19 19 66 to SEPT 23 19 66, that (I) (we) last saw the deceased alive on SEPT 23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kenneth R Koskinen M.D.				23B. DATE SIGNED Sept 23, 1966.	
23C. PHYSICIAN'S NAME (Type) KENNETH R KOSKINEN MD		23D. ADDRESS UNIVERSITY HOSPITAL BALTO., MD 21201			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 9/24/66		24C. NAME OF CEMETERY or CREMATORY Workmen's Circle	
24D. LOCATION Baltimore, Conn		24E. DATE REG'D BY HEALTH DEPT. SEP 25 1966			
25B. NAME OF REGISTRAR J. C. [unclear]		25C. FUNERAL DIRECTOR Sol Jernigan - [unclear] Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09672</b>	
BIRTH NO. <b>66 09672</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>SIDNEY S. GREEN</b>		2. DATE AND HOUR OF DEATH <b>9/24/66</b>   <b>2:15 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-20</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>5915 WINNER AVE</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>6/4/18</b>	9. AGE (In years lost birthday) <b>48</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>		11. BIRTHPLACE (State or foreign country) <b>Rankin, Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Late Max Green</b>		14. MOTHER'S MAIDEN NAME <b>Lina Berger</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>209-10-9732</b>		17. INFORMANT <b>Mrs. Alicia Green</b> ADDRESS <b>5915 Winner Avenue</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Coronary Occlusion</b> DUE TO (B) <b>Coronary sclerosis</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>2 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>6</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1964</b> to <b>Sept 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 24 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Irvin Sauder</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9-24-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>IRVIN SAUDER</b>		23D. ADDRESS <b>6905 Park Hgts Ave</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/25/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Beth Tiloah,</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros. 6010 Reisterstown Rd.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>CLARA J. JONES</b>		25C. ADDRESS	

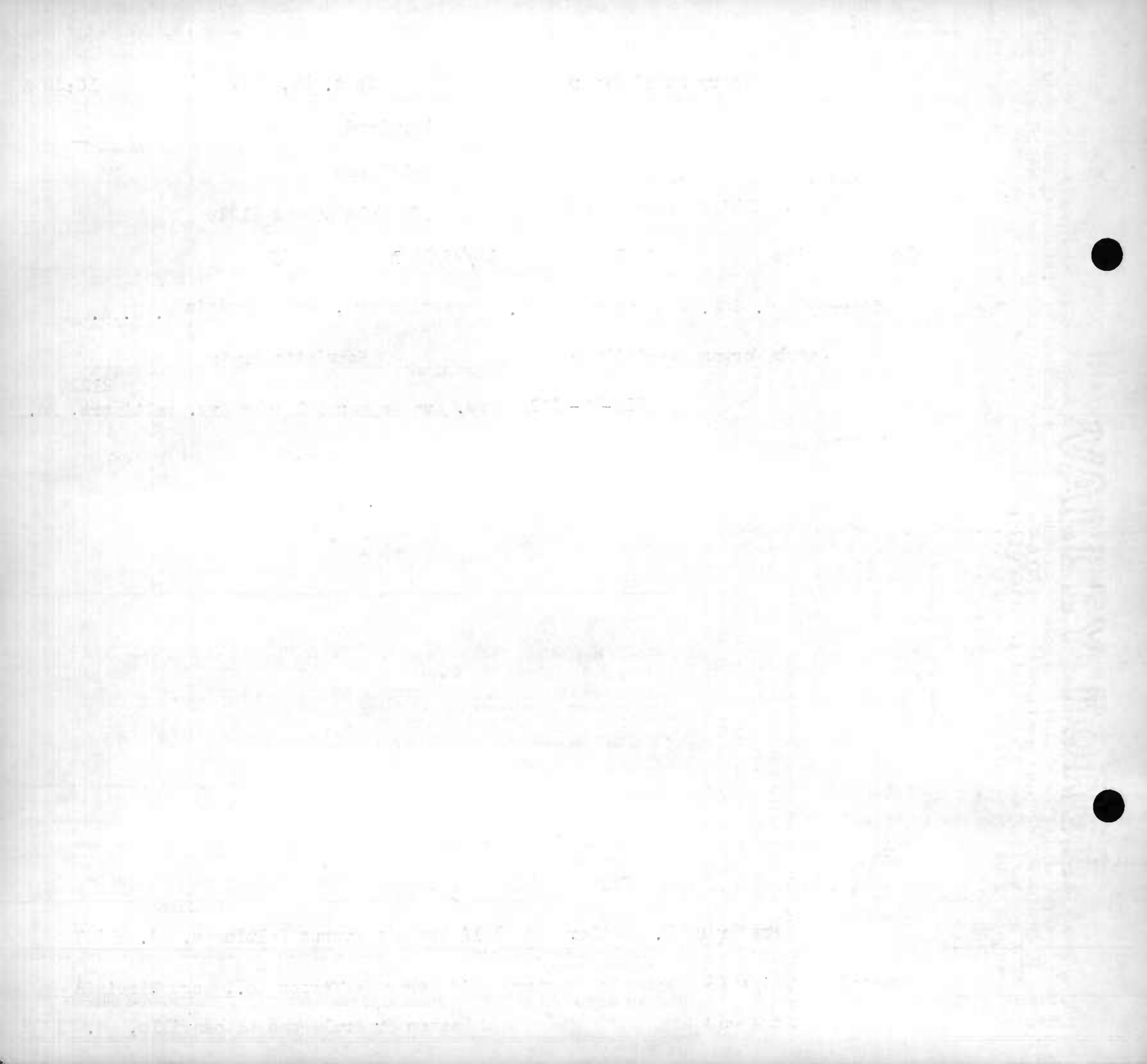




# FUNERAL DIRECTOR: IMPORTANT

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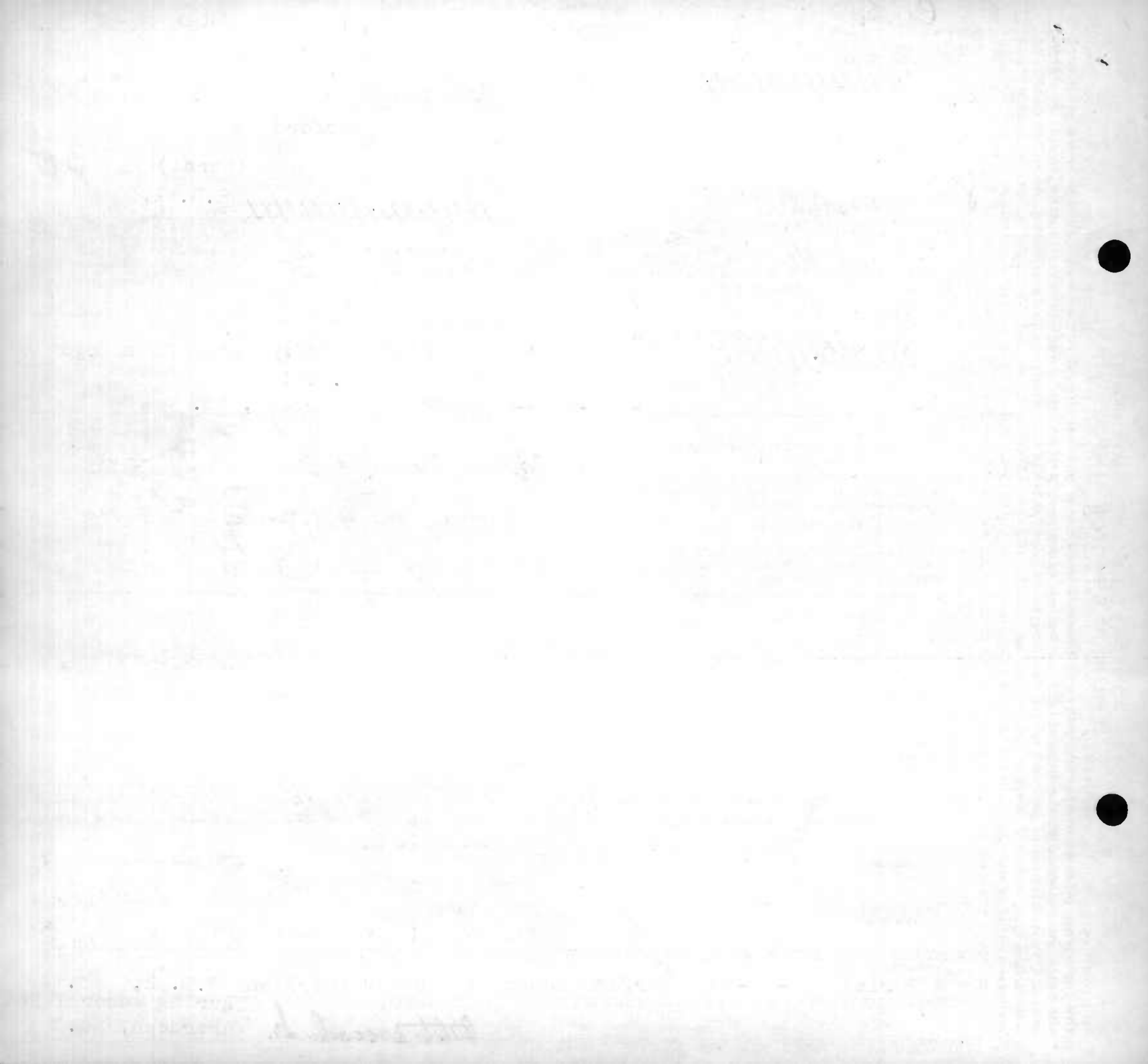
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09673	
BIRTH NO. 66 09673		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Henry Sencindiver			2. DATE AND HOUR OF DEATH Sept. 22, 1966 10:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Saint Agnes Hospital Caton & Wilkins Avenue 21229			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 2531 D. STREET ADDRESS (If rural, give location) 509 Yale Avenue 21229		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 10/25/1881	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney U. S. F. & G Insurance Co.			11. BIRTHPLACE (State or foreign country) Martinsburg, West Virginia U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Jacob Morgan Sencindiver			14. MOTHER'S MAIDEN NAME Henrietta Kratz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-07-8171	17. INFORMANT ADDRESS Mrs. Eva Wagner 501 Yale Ave. Baltimore, Md. 21229		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I 411X I Neutral valvular heart disease Rubeola pharyngeal fever Chronic gonitis CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 year					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 6 1966 to Sept 11 1966 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jordan J. Barber			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9-23-66
23C. PHYSICIAN'S NAME (Type) Frederick V. Beitler			23D. ADDRESS 1014 Francis Avenue Baltimore, Md. 21227		
24A. BURIAL CREMATION, REMOVAL (Specify) Removal	24B. DATE 9/24/1966	24C. NAME OF CEMETERY or CREMATORY Masonic Cemetery		24D. LOCATION (City, town, or county) (State) Middleway Jefferson Co., West Virginia	
25A. DATE REC'D BY HEALTH DEPT. SEP 26 1966		25B. NAME OF REGISTRAR R. E. S. S. S.		25C. FUNERAL DIRECTOR ADDRESS Easton Funeral Home Catonsville, Md. 21228	



# FUNERAL DIRECTOR: IMPORTANT

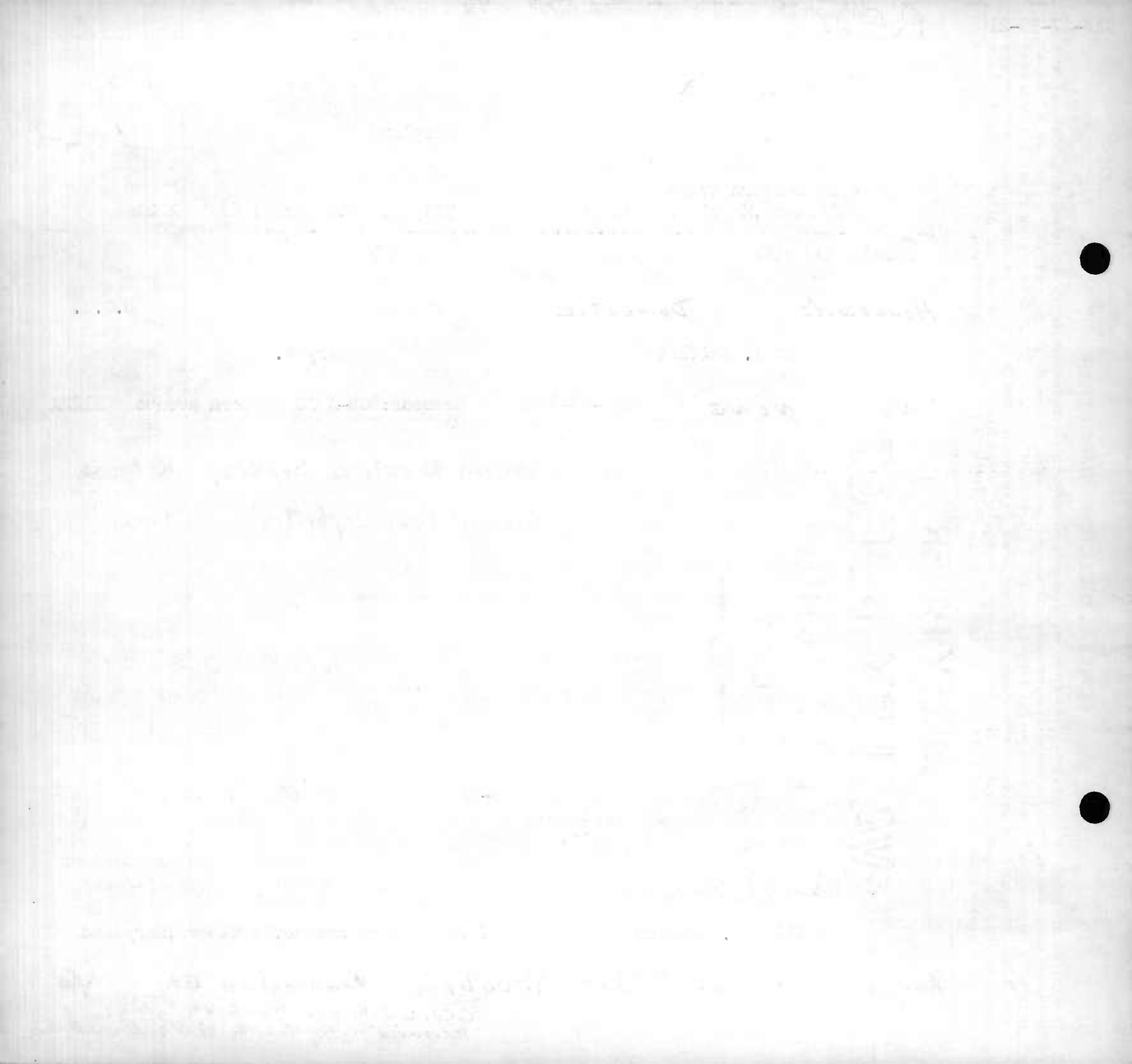
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B 300 66 09674		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09674	
BIRTH NO.		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
WANDA XXXXX BOYD / WANDA JEAN BOYD		9/22 / 66		3:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL OF MARYLAND		A. STATE MD. B. COUNTY Harford			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) ABERDEN (Rural) 62-00			
		D. STREET ADDRESS (If rural, give location) <del>XXXXXXXXXXXX</del> R.D. 1, Box 108			
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 11/30/55	9. AGE (In years last birthday) 10 10/12	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child N/A		10B. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Roy Gilbert Boyd			
14. MOTHER'S MAIDEN NAME <del>XXXXXXXXXXXX</del> Ester June Boyd		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. -- -- --		17. INFORMANT Father R.D. 1 Aberdeen, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Uremia		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Pyelonephritis		(B) DUE TO		7 yrs	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/20 19 66 to 9/22 19 66, that (I) (we) last saw the deceased alive on 9/22 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Kerama		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/22/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS University Hospital of Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-26-66		24C. NAME of CEMETERY or CREMATORY Harford Memorial Gardens	
24D. LOCATION Aberdeen		R.D. 2, Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 26 1966		25B. NAME OF REGISTRAR J. Kerama		25C. FUNERAL DIRECTOR Tarring Funeral Home	
Aberdeen, Md.					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>R520</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09675</b>	
M.E. CASE NO. <b>66 09675</b>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Julia S. Raynes</b>			2. DATE AND HOUR OF DEATH <b>9-24-66</b> <b>1:05 AM</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>			A. STATE <b>Maryland</b> B. COUNTY <b>1-01</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>3139 Elliott Street 21224</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>10-12-97</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>James P. Shiflett</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>225-05-8675</b>		
17. INFORMANT <b>Records: BCH-4940 Eastern Avenue 21224</b>			ADDRESS		
18. <b>600.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Gram Negative Sepsis</b> DUE TO <b>Chronic Pyelonephritis</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b> <b>1 year</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>7-24</b> 19 <b>66</b> , <b>9-24-66</b> 19 that (1) (we) last saw the deceased alive on <b>9-24-66</b> 19 and that (1) (my) (our) apianian death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William A. Emerson</b>				23B. DATE SIGNED <b>9-24-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>William A. Emerson</b>				23D. ADDRESS M.D. <b>4940 Eastern Avenue, Baltimore, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-27-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Port Republic Rockingham Cty VA.</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>			
25B. NAME OF REGISTRAR <b>Edith E. Schaefer</b>		25C. FUNERAL DIRECTOR <b>Geo. L. Schwab Funeral Home</b> <b>Thomas H. Miller 2101 Frederick Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M 000</u>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 09676</u>	
M.E. CASE NO. <u>66 09676</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Katherine Watson May</u>				2. DATE AND HOUR OF DEATH <u>9/21/66</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Anderson Nursing Home</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>15-38</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>21207</u> <u>3408 Fairview Rd.</u>			
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>11-20-1888</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Companion</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Charles Augustus Watson</u>				
14. MOTHER'S MAIDEN NAME <u>Mary Ellen Widmyer</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				
16. SOCIAL SECURITY NO. <u>218-37-3389</u>			17. INFORMANT ADDRESS <u>Mr. Roy P. May Jr. 3408 Fairview Rd. 21207</u>				
18. <u>491X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 20</u> 19 <u>66</u> to <u>September 19</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 20</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Raphael Perez-Mera</u>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>Raphael Perez-Mera, M. D.</u>	
23D. ADDRESS <u>7306 Liberty Rd. Balt. 21207, Md.</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>9/24/66</u>				24C. NAME OF CEMETERY or CREMATORY <u>Greenmount Cemetery-Greenmount Ave. &amp; Oliver-Balt., Md.</u>		24D. LOCATION (City, town, or county) (State) <u>Balt. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1966</u>		25B. NAME OF REGISTRAR <u>SEP 26 1966</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Loring Byers-8728 Liberty Rd. Randallstown</u>			



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>66 09677</u>				
BIRTH NO. <u>66 09677</u>					1. NAME OF DECEASED (Type or Print) <u>P. STEWART MACAULAY</u>				
2. DATE AND HOUR OF DEATH <u>22 SEPTEMBER 1966 8<sup>00</sup> P.M.</u>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 THE JOHNS HOPKINS HOSPITAL</u>					A. STATE <u>MARYLAND</u>				
					B. COUNTY <u>27-12</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>				
					D. STREET ADDRESS (If rural, give location) <u>305 THORNHILL ROAD</u>				
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>3-24-01</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Exec. Vice Pres. of Johns Hopkins Univ.</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Nova Scotia</u>			11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE MACAULAY</u>					14. MOTHER'S MAIDEN NAME <u>MARGARET ROSE</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Elizabeth Macaulay 305 Thornhill Road</u>				
18. <u>527.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) cardiac arrhythmia</u> <u>(B) cardiac failure + irritability</u> <u>(C) chronic obstructive lung disease</u>					<u>13 days</u> <u>3 years</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>atherosclerotic hypertensive + cardio vascular disease 3+ years</u>									
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>8 SEPT.</u> 19 <u>66</u> to <u>22 SEPT.</u> 19 <u>66</u> , that <del>we</del> (we) last saw the deceased alive on <u>22 SEPT.</u> 19 <u>66</u> and that in <del>the</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>We</del> (We) (did) <del>the</del> view the body after death.									
23A. SIGNATURE <u>Daniel C. Hadlock</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>22 Sept. 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>DANIEL C. HADLOCK</u>					23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>				
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/26/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore County, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1966</u>			25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Mitchell-Wiedefeld Inc. 6500 York Rd. Baltimore, Maryland 21212</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B6341		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09678	
BIRTH NO. 66 09678		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Marie-Louise Bradley		2. DATE AND HOUR OF DEATH 9/23/66 8 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 13-07			
FULL NAME OF HOSPITAL OR INSTITUTION 622 W. University Parkway		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 622 W. University Parkway			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Nov. 27, 1912	9. AGE (In years lost birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brooklyn, New York	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles Hughes			14. MOTHER'S MAIDEN NAME Louise McGuire		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT James E. Bradley Jr. 622 W. University Parkway	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 170X I Generalized Metastases from Ca of Right Breast (post operative 2 1/2 yrs.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH Generalized Metastases from Ca of Right Breast (post operative 2 1/2 yrs.) Acute Myelocytic Leukemia 3 mos.		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in at about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 19 62 to Sept. 19 66, that (I) last saw the deceased alive on 9/22 19 66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.					
23A. SIGNATURE Wm. H. Kammer, Jr. M.D.				23B. DATE SIGNED 9/23/66	
23C. PHYSICIAN'S NAME (Type) Dr. William Kammer M.D.				23D. ADDRESS 6011 York Road	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/26/66		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. SEP 26 1966		24F. NAME OF REGISTRAR G. J. S. S. S.	
24G. FUNERAL DIRECTOR Mitchell-Wiedefeld Inc. 6500 York Rd. Balto., Md. 21212		24H. ADDRESS			

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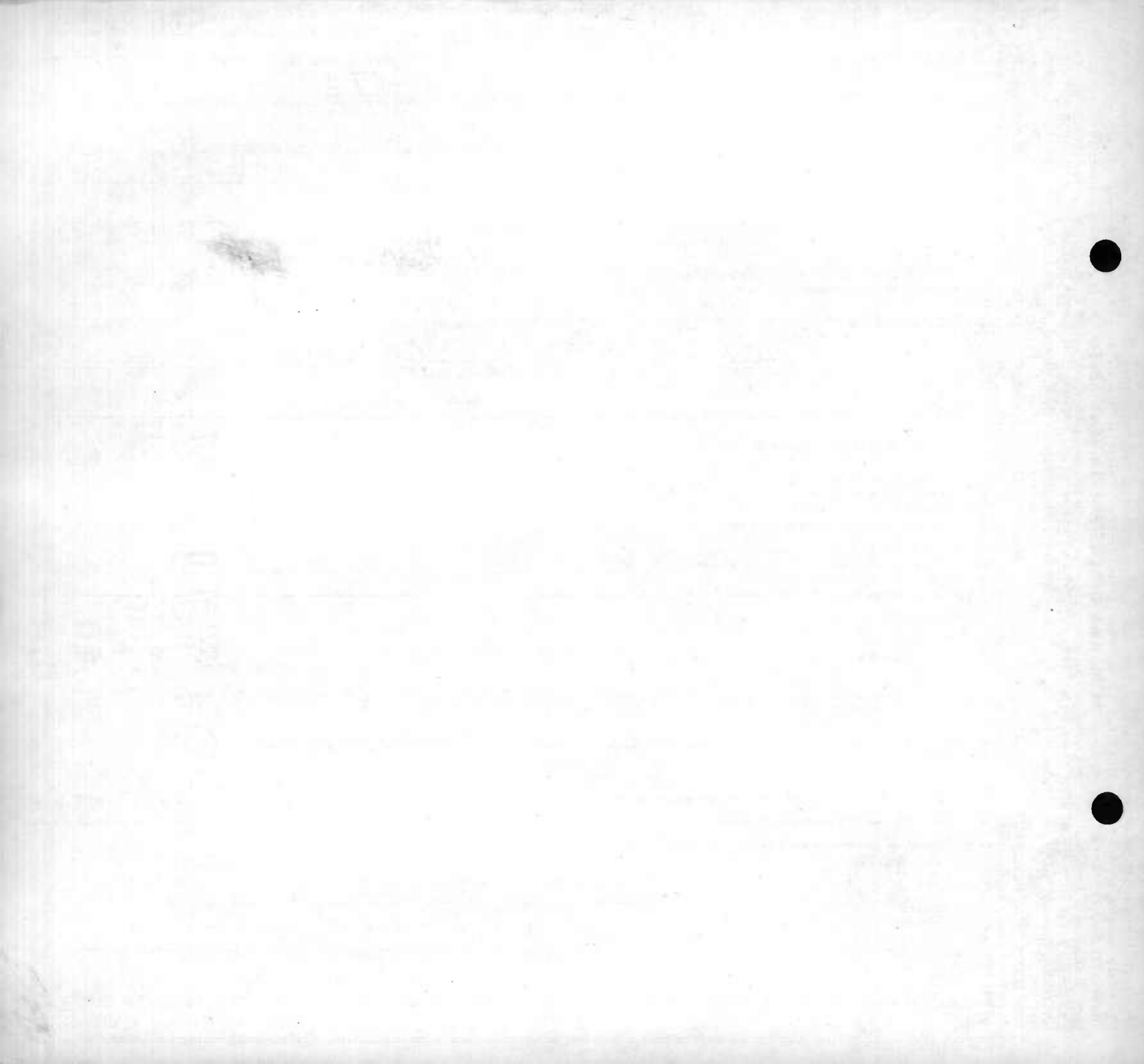
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 09679		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		66 09679	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>EVELYN JOHNSON</b>				2. DATE AND HOUR OF DEATH <b>7:45 PM 9/18/66</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)				A. STATE <b>Balto. Md.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY Hospital Balto. Md.</b>				B. COUNTY <b>AL</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto. Md. 5200</b>	
D. STREET ADDRESS (If rural, give location) <b>301 Key Ave.</b>				5. SEX <b>F</b>				6. RACE <b>Negro</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>				8. DATE OF BIRTH <b>11/26/1904</b>				9. AGE (In years, last birthday) <b>61 YRS</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>?</b>				11. BIRTHPLACE (State or foreign country) <b>MARYLAND S.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>BARNEY BENNETT</b>				14. MOTHER'S MAIDEN NAME <b>CORNELIA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>S/A</b>				17. INFORMANT ADDRESS <b>MRS ROSIE BROOK S/A</b>	
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Probable Myocardial Infarction</b>				CAUSE OF DEATH (A) DUE TO <b>Ante-mortem CVD</b>				INTERVAL BETWEEN ONSET AND DEATH <b>48 Hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/15</b> <b>1966</b> to <b>9/17</b> <b>1966</b> that (I) (we) last saw the deceased alive on <b>9/17</b> <b>1966</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>I. M. Sopher</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>9/18/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>IRVIN M. SOPHER</b>				M.D. ADDRESS <b>UNIVERSITY Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>9-22-66</b>				24C. NAME OF CEMETERY or CREMATORY <b>MOUNT CALVARY CEM</b>	
24D. LOCATION (City, town, or county) (State) <b>ARUNDEL Co. Md.</b>				25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>				25B. NAME OF REGISTRAR <b>I. L. BROWN</b>	
25C. FUNERAL DIRECTOR <b>I. L. BROWN</b>				ADDRESS <b>123 W. MONTGOMERY ST.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09680</u>	
BIRTH NO. <u>66 09680</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>James James</u>		2. DATE AND HOUR OF DEATH <u>9-18-66</u> <u>6:30 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>23-01</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore # 21230</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hosp.</u>		D. STREET ADDRESS (If rural, give location) <u>942 Leadenhall St.</u>			
5. SEX <u>M.</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widower</u>	8. DATE OF BIRTH <u>1-15-11</u>	9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>unk</u>		14. MOTHER'S MAIDEN NAME <u>unk</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-12-173</u>		17. INFORMANT ADDRESS <u>Sarah Gantt</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Thrombosis</u>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (we) (this hospital) attended the deceased from <u>9-16</u> 19 <u>66</u> to <u>9-18</u> 19 <u>66</u> , that (we) last saw the deceased alive on <u>9-18</u> 19 <u>66</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Colen C. Heinritz</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-19-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Colen C. Heinritz</u>		23D. ADDRESS <u>South Baltimore General Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-22-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mount Calvary Cem</u>	
24D. LOCATION (City, town, or county) (State) <u>Arundel Co Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1966</u>		25B. NAME OF REGISTRAR <u>Lab 2. [unclear]</u>	
25C. FUNERAL DIRECTOR <u>J.L. Brown &amp; Son</u>		ADDRESS <u>108 W. Montgomery</u>			

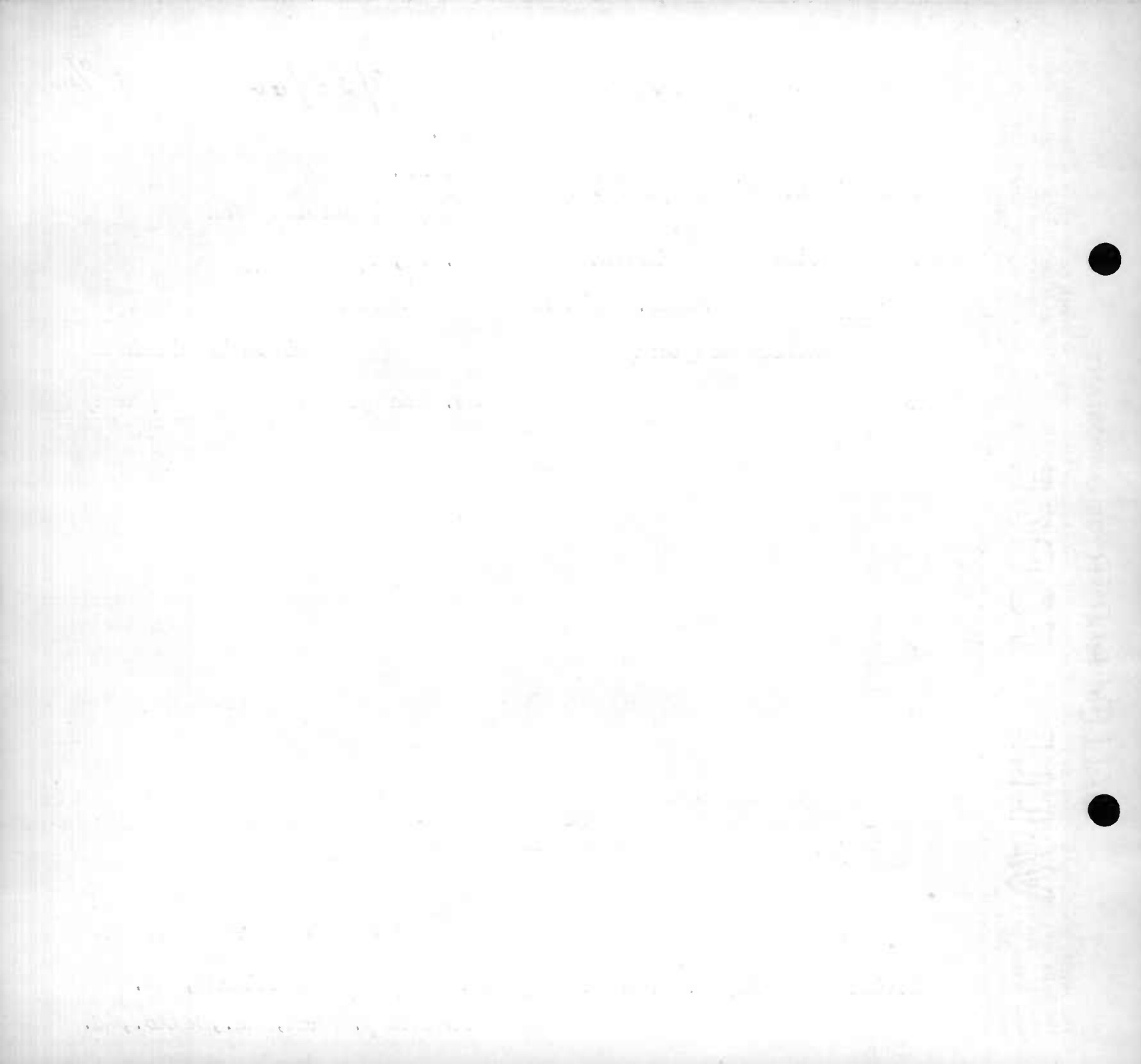




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 09681		<b>CERTIFICATE OF DEATH</b>		66 09681	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Mr. Cleary, Clarence</i>		2. DATE AND HOUR OF DEATH <i>9/25/66 9:50 AM. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 House in The Pines (Belaire)</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto. #34 5300</i> D. STREET ADDRESS (If rural, give location) <i>3117 Willoughby Road</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Jan. 12, 1873</i>	9. AGE (In years lost birthday) <i>93</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Penna. Railroad</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Wesley Mc Cleary</i>		14. MOTHER'S MAIDEN NAME <i>Minervia Williams</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Ada Chason</i>	
ADDRESS <i>(Same)</i>					
18. <i>420, 1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Coronary thrombosis</i> DUE TO (B) <i>arteriosclerotic heart disease</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1966</i> 19 <i>Sept 26</i> 19 <i>66</i> that (I) <del>was</del> last saw the deceased alive on <i>9/10</i> 19 <i>66</i> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) (didn't) view the body after death.					
23A. SIGNATURE <i>James E. White</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>26 Sept 66</i>	
23C. PHYSICIAN'S NAME (Type) <i>James E. White</i>		23D. ADDRESS <i>5214 HARFORD ROAD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/28/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 26 1966</i>		25B. NAME OF REGISTRAR <i>John E. ...</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc., Balto., Md.</i>	
ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 66 09682	
BIRTH NO. 66 09682						M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <b>PATRICK PAUL VITO</b>				2. DATE AND HOUR OF DEATH <b>sept. 24. 1966 343 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSP</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>501</b>			
5. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>				6. STREET ADDRESS (If rural, give location) <b>3605 Harford Road</b>			
7. SEX <b>Male</b>	8. RACE <b>white</b>	9. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	10. DATE OF BIRTH <b>04-20-03</b>	11. AGE (In years last birthday) <b>63</b>	12. If Under 1 Yr. Months: Days: Hours: Min.	13. If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fruit dr.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>NICHOLAS VITO</b>			14. MOTHER'S MAIDEN NAME <b>Mary X unknown</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Florence M. Vito</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>420.1 I</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary heart disease</b>			CAUSE OF DEATH <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO			(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Status post bowel resection for incarcerated ventral hernia			Sh	
19A. DATE OF OPERATION <b>19/23/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>incarcerated hernia</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>heart, abdomen</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <b>sept 23 1966</b> to <b>sept 24 1966</b> , that (we) last saw the deceased alive on <b>sept. 24 343pm 19 66</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE <b>Giselle T. Bretz</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9. 24. 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Giselle T. Bretz</b>				23D. ADDRESS <b>UNION MEMORIAL HOSP</b> <b>The Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/28/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>SEP 26 1966</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>		ADDRESS	

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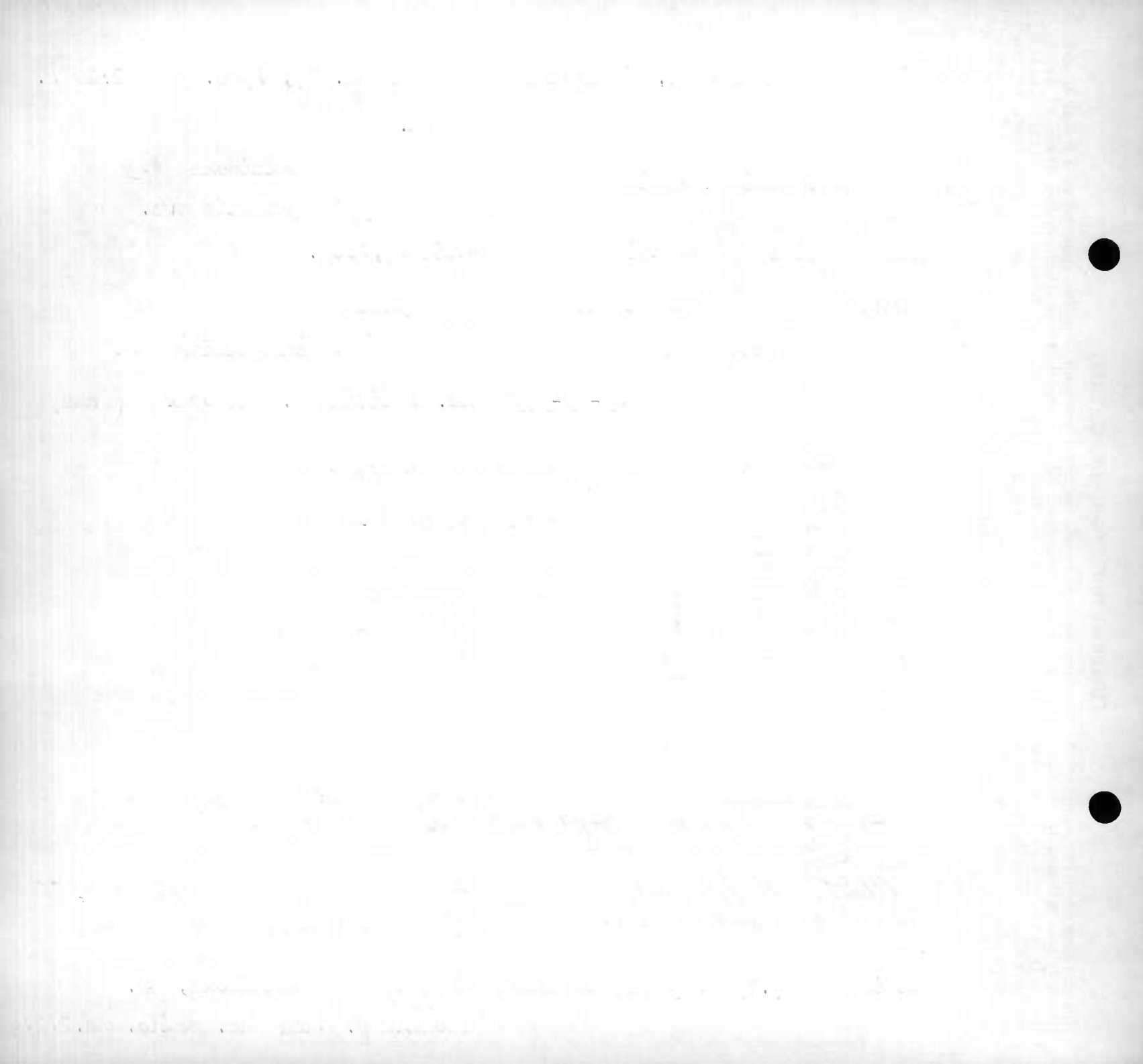
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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09683</u>	
BIRTH NO. <u>66 09683</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Peter H. Marcoplos</u>		2. DATE AND HOUR OF DEATH <u>Sept. 24, 1966.</u> <u>2:20 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>		A. STATE <u>Md.</u> B. COUNTY <u>27-18</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore #15</u>			
		D. STREET ADDRESS (If rural, give location) <u>5322 Cordelia Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED <u>Married</u>	8. DATE OF BIRTH <u>April 14, 1885</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry Marcoplos</u>		14. MOTHER'S MAIDEN NAME <u>Constantina ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-07-5452</u>		17. INFORMANT ADDRESS <u>Mrs. Telisida D. Marcoplos (Same)</u>	
18. <u>4 20 1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Coronary occlusion</u> DUE TO (B) <u>Arteriosclerotic heart disease</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>8 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Nov 4, 1957</u> to <u>Sept 24, 1966</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Sept 13, 1966</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <u>Abraham B. Hurwitz</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Sept. 26, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>ABRAHAM B. HURWITZ</u>		23D. ADDRESS M.D. <u>7501 Liberty Road, Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/27/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Greek Orthodox Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1966</u>		25B. NAME OF REGISTRAR <u>John B. E. [unclear]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 09684		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09684	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Allen C. Minor, Sr.		2. DATE AND HOUR OF DEATH Sept. 24, 1966. 7 <sup>30</sup> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		A. STATE Md.		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN Baltimore #14		(If outside city limits, write RURAL and give township)	
		D. STREET ADDRESS 6205 Birchwood Ave.		(If rural, give location)	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 24, 1909	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Packer		10B. KIND OF BUSINESS OR INDUSTRY Esskay Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John C. Minor		14. MOTHER'S MAIDEN NAME Ethel Mae Heller	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. 220-18-4051		17. INFORMANT Mrs. Mary E. Minor	
18. 465-X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Massive Pulmonary Embolism (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from May 1956 to Sept 1966, that (1) (we) last saw the deceased alive on 9/23 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. M. Smith		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/26/66	
23C. PHYSICIAN'S NAME (Type) W. M. Smith		23D. ADDRESS 6305 (Clarinda) Blvd 12			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/27/66		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Baltimore, Md.		24E. NAME of CEMETERY or CREMATORY		24F. LOCATION (City, town, or county)	
25A. DATE REC'D BY HEALTH DEPT. SEP 26 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214	
25D. ADDRESS		25E. NAME OF REGISTRAR		25F. FUNERAL DIRECTOR	

The following information is being provided for your information.

The information is being provided for your information.

The information is being provided for your information.

The information is being provided for your information.

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
66 09685				66 09685				66 09685			
M.E. CASE NO.				CERTIFICATE OF DEATH				Registered No.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
SANDERS, EDWIN LEO				9-23-66				4:15A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE				B. COUNTY			
ST. AGNES HOSPITAL				MARYLAND				BALTO			
CERTIFICATE AMENDED 10-4-66				C. CITY OR TOWN (If outside city limits, write RURAL and give township)				BALTIMORE 21234			
D. STREET ADDRESS (If rural, give location)				2924 WILLOUGHBY ROAD							
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost, birthday)		10. If Under 1 Yr. Months Days	
MALE		WHITE		MARRIED		12-16-19		46			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
SEAMAN				MARITIME				MARYLAND			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
EDWIN				MARGARET TOWNSLEY				U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
YES- NO				213 12 0715				ST. AGNES RECORDS-CATON & WILKENS AVES			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO				Liver Cirrhosis			
ANTECEDENT CAUSES				(B) DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Atelectasis, Bilateral							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
0											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 18 19 66 to SEPTEMBER 23 19 66, that (I) (we) last saw the deceased alive on SEPTEMBER 23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED			
ROLANDO DEL ROSARIO								9-23-66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
				M.D. ST AGNES HOSPITAL, BALTO., MD.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		9-26-66		Bel Air Memorial Gardens		Bel Air, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
SEP 26 1966		J. J. H. J. J. H.		Wm. Cook-Brooks		Towson, Md.					



## CERTIFICATE OF DEATH

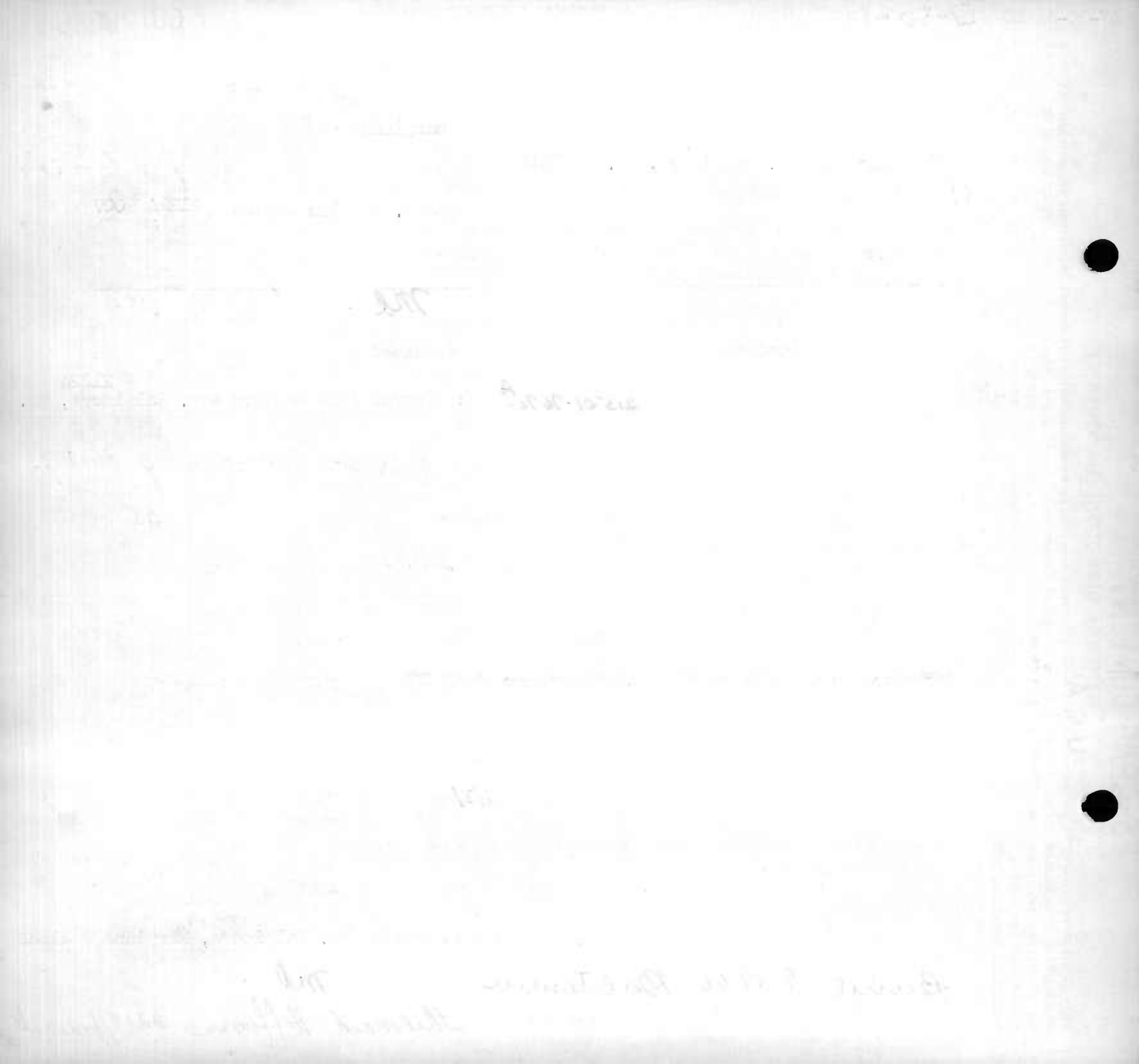
Registered No.

86 09686

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				JOHN H. DIMICK		9-23-66 12:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 4940 Eastern Ave. Baltimore, Md. # 21224 BALTIMORE CITY HOSPITAL				A. STATE Maryland			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO MD. 26-09			
				D. STREET ADDRESS (If rural, give location) 904 S. Baylis Street 21224 007			
5. SEX Male	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 2-19-86	9. AGE (In years last birthday) 80	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Deceased				14. MOTHER'S MAIDEN NAME deceased			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-7670-A		17. INFORMANT ADDRESS # 21224 BCH: Records 4940 Eastern Ave. Baltimore, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) CARDIAC & RESP. ARREST DUE TO (B) SHOCK DUE TO (C) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 30 MIN. 35 MIN.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				① PNEUMONITIS ② STATUS POST ABDOMINAL ANEURYSMECTOMY ③ STATUS POST TRANS. COLOSTOMY FOR DIVERTICULOSIS			
19A. DATE OF OPERATION 8-24-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RECTAL BLEEDING, ABD. ANEURYSM.		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/21/66 to 9/23/66, that (I) (we) last saw the deceased alive on 9/23/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE facher				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/23/66	
23C. PHYSICIAN'S NAME (Type) SHIAO-CHIU ANDREW CHEN				23D. ADDRESS M.D. 4940 Eastern Ave. Baltimore, Maryland # 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-27-66		24C. NAME of CEMETERY or CREMATORY Baltimore		24D. LOCATION (City, town, or county) (State) MD.	
25A. DATE REC'D BY HEALTH DEPT. SEP 26 1966		25B. NAME OF REGISTRAR Paul E. Johnson		25C. FUNERAL DIRECTOR Thelma Hoffmann		ADDRESS 3218 Judson St	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

CHARLES Joseph Ceska

2. DATE AND HOUR PRONOUNCED DEAD

September 24, 1966 2:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2426 Greenmont Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2426 Greenmont Avenue #18

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

3/20/1900

9. AGE (In years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Musician (Ret.)

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Navy

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles F. Ceska

14. MOTHER'S MAIDEN NAME

Marie S. Kapralko

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

yes

11/22/21 to 12/13/44

16. SOCIAL  
SECURITY NO.

212-28-3788

17. INFORMANT

ADDRESS

cousin.

Margaret Schiminger, 3105 Weaver Ave. #11

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular  
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/24/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9/28/66

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Schimunek Funeral Home, Inc.

2601-03-05 E. Madison Street #5

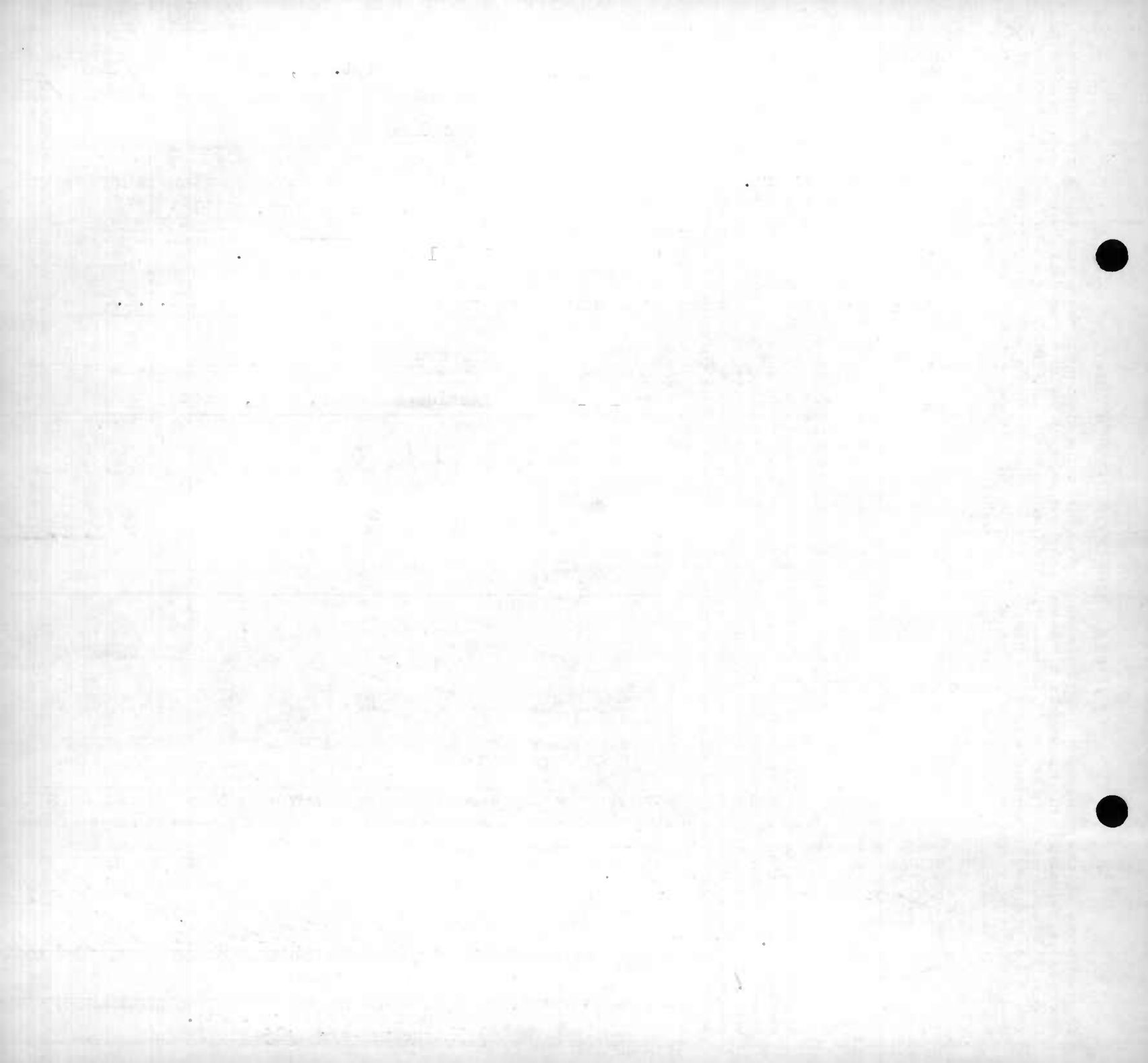
WALTER D. GIBSON

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">66 09688</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 1.5em;">66 09688</span>	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH Sept. 24, 1966 <span style="font-size: 1.5em;">9 25 A.M.</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Gustave DeBouver</span>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">1106 Gorsuch Ave. Baltimore, Maryland 21218</span>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore <span style="font-size: 1.5em;">9-05</span>			
D. STREET ADDRESS (If rural, give location) 1106 Gorsuch Avenue, 21218		5. SEX male			
6. RACE white		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 12/1/1877	
9. AGE (In years last birthday) 88 yrs.		10. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dates of service) no		11. BIRTHPLACE (State or foreign country) France	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10B. KIND OF BUSINESS OR INDUSTRY Suburban County Club		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dates of service) no	
16. SOCIAL SECURITY NO. 215-03-8616		17. INFORMANT Leonide DeBouver, wife, above			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) DUE TO Heart failure		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
(B) DUE TO Arteriosclerosis		(C) DUE TO		4 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1964 to 9/24 1966 that (I) (we) last saw the deceased alive on 9/24 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Conrad L. Richter</span>				23B. DATE SIGNED 9/28/66	
23C. PHYSICIAN'S NAME (Type) Conrad L. Richter				23D. ADDRESS 3128 Hanford Rd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/27/66		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 26 1966		25B. NAME OF REGISTRAR J. J. J. J.	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		25D. ADDRESS 3331 Brehms Lane #13		25E. ADDRESS	



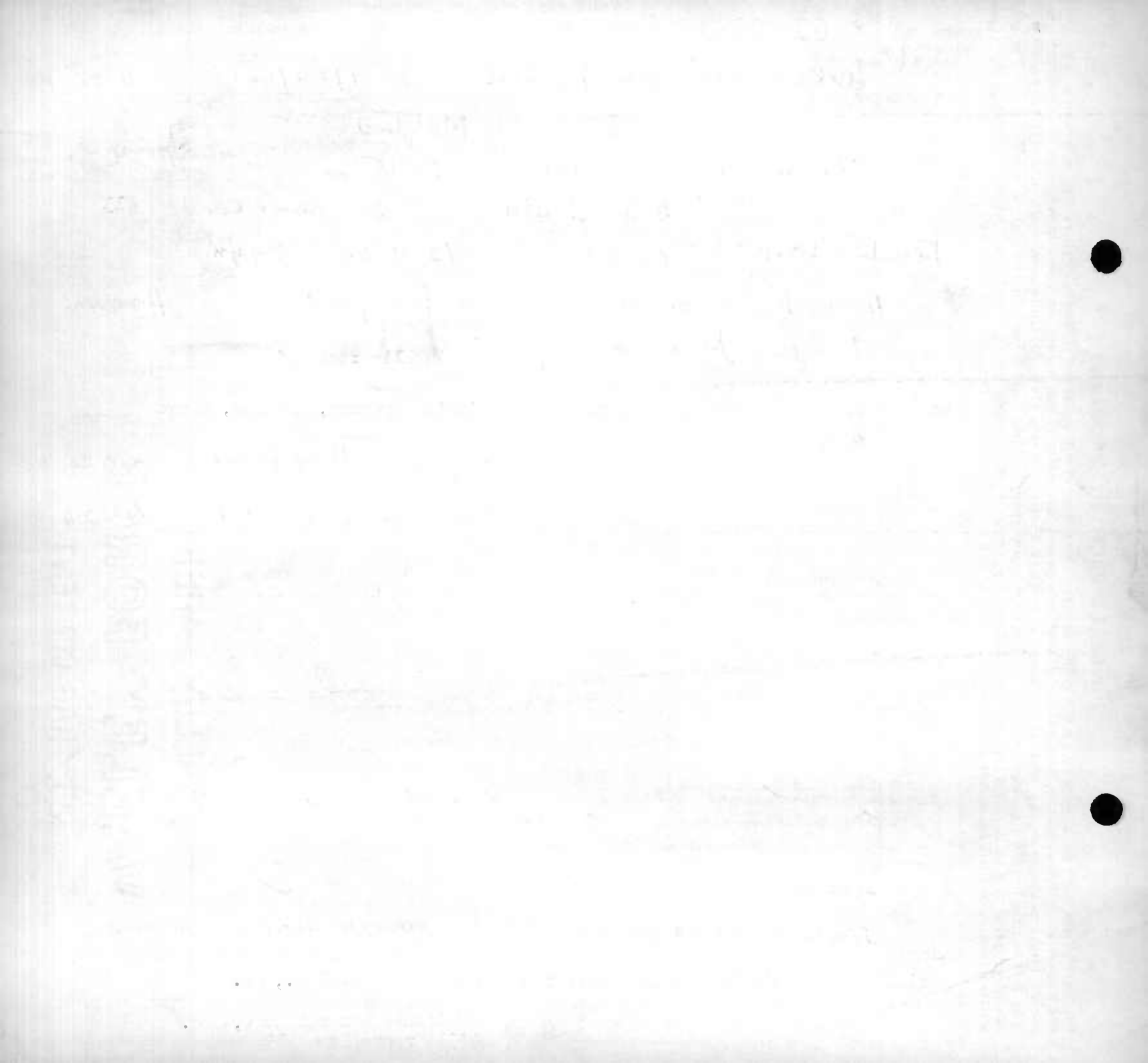




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09689		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 09689	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BRENNAN Mx ROSALIE</b>		2. DATE AND HOUR OF DEATH <b>9/24/66 11-05 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location) <b>Church home &amp; hospital 100. N Broadway Baltimore 21231</b>		A. STATE <b>Maryland</b> B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 26-03</b>		D. STREET ADDRESS (If rural, give location) <b>3825 Belair Road #13</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>12-9-06</b>	9. AGE (In years last birthday) <b>59 yrs</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>American</b>		13. FATHER'S NAME <b>Joseph Perkowski</b>		14. MOTHER'S MAIDEN NAME <b>Phyllis Taminski</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no Unknown</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>William Brennan, husband, above</b>	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <b>Congestive Heart Failure</b> (B) DUE TO <b>Cerebrovascular accident</b> (C)		INTERVAL BETWEEN ONSET AND DEATH <b>8-20-66 to 9-24-66</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS RESULTING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-20-1966</b> to <b>9-24-1966</b> that (I) (we) last saw the deceased alive on <b>9-24-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William Brennan</b>				23B. DATE SIGNED <b>9-24-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>IDILIA C MARIANO</b>		23D. ADDRESS <b>CHURCH HOME &amp; HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/28/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>			
25B. NAME OF REGISTRAR <b>R. L. E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane #13</b>			



1  
W-560

66 09690

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09690

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE

WIMMER

2. DATE AND HOUR PRONOUNCED DEAD

September 23, 1966 2:07 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

John Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3223 Lawnview Avenue #13

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

6/16/94

9. AGE (In years  
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Electricians Helper

10B. KIND OF BUSINESS OR INDUSTRY

Local Union E-28

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Wimmer

14. MOTHER'S MAIDEN NAME

Catherine ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

yes

WWI

16. SOCIAL  
SECURITY NO.

212-01-0245

17. INFORMANT

ADDRESS

Sadie Wimmer, wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular  
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/24/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9/27/66

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 26 1966

24B. NAME OF REGISTRAR

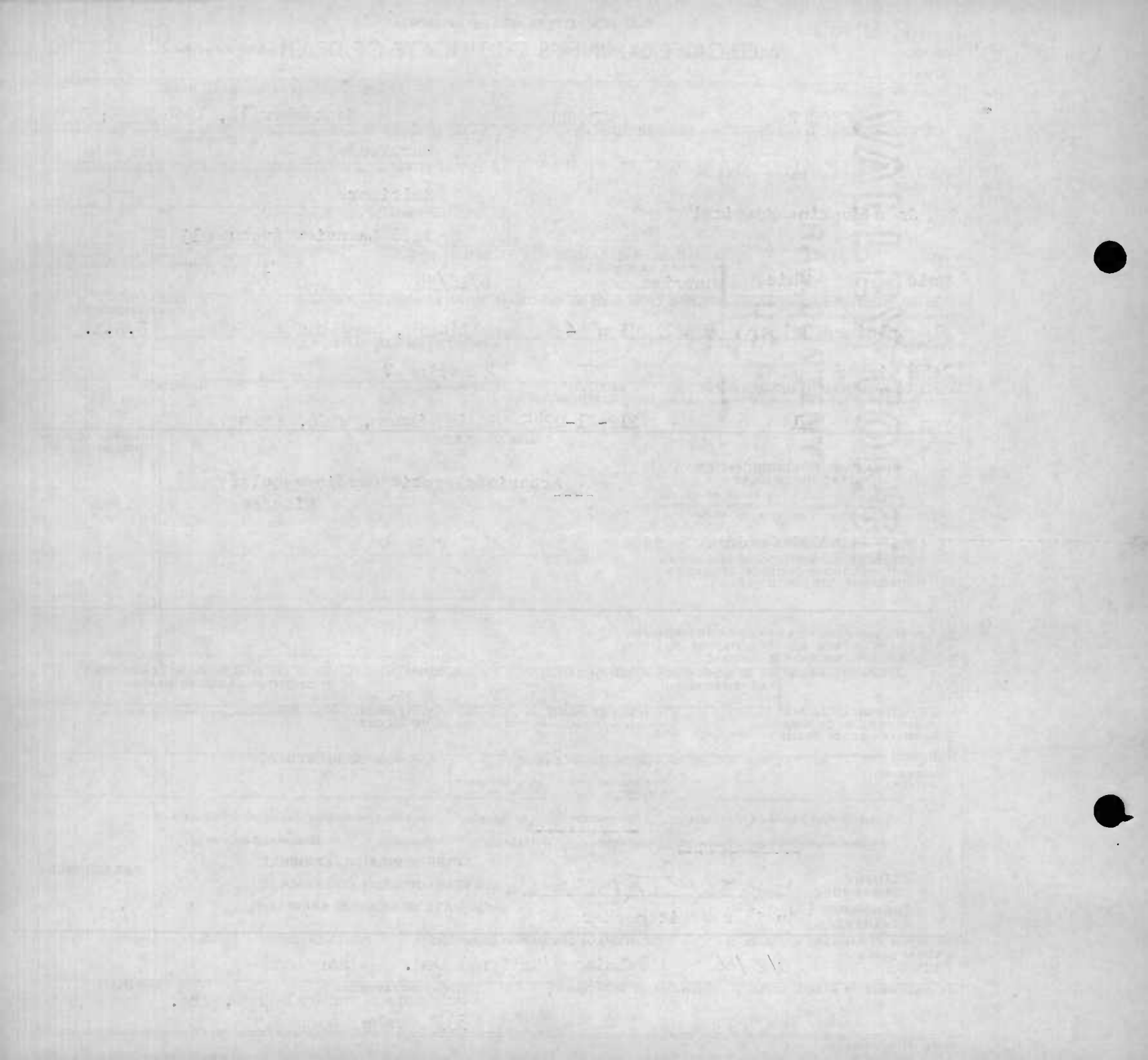
Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

3331 Brehms Lane #13



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09691	
BIRTH NO. 66 09691		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MRS. FRANCES POOLE WALTERS		2. DATE AND HOUR OF DEATH 9-22-66 10: P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL		A. STATE MARYLAND		B. COUNTY 27-05	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		21206	
		D. STREET ADDRESS (If rural, give location) 6510 BELAIR ROAD			
5. SEX F	6. RACE W	7. MARRIAGE, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 11-24-90	9. AGE (In years last birthday) 75	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Ricketts		14. MOTHER'S MAIDEN NAME Frances P. Ricketts	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-01-3373		17. INFORMANT SON JOHN WALTERS	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) CEREBRAL HEMORRHAGE DUE TO (B) Hypertension DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Sept 17-66 19 to Sept 22 19-66, that (I) (we) last saw the deceased alive on Sept 22 19-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Sidney E. Kirkley M.D.		23B. DATE SIGNED 22 Sept. 66		23C. PHYSICIAN'S NAME (Type) SIDNEY E. KIRKLEY	
23D. ADDRESS THE UNION MEMORIAL HOSPITAL		23E. NAME OF REGISTRAR Robert E. Taylor M.D.		23F. FUNERAL DIRECTOR John C. Miller / Inc. - 6415 Belair Rd. - 21206	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 9-26-66		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. ADDRESS		24F. DATE REC'D BY HEALTH DEPT. SEP 26 1966	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 66 09692	
CERTIFICATE OF DEATH							
BIRTH NO. 66 09692							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <i>McGraw, Thomas F.</i>				2. DATE AND HOUR OF DEATH <i>Sept. 23-66 12:20 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 Bon Secours Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>4th Street</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>3710 Fourth St.</i>			
5. SEX <i>Male</i>	6. RACE <i>Caucasian</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>4/25/92</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
13. FATHER'S NAME <i>Nicholas McGraw</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Furlong</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-03-1073</i>		17. INFORMANT <i>Mrs. M. B. Ripken - 3710 Fourth St. - 21225</i>		ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Pulmonary fibrosis</i> DUE TO <i>&amp; Respiratory Insufficiency</i> (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>1 year &amp; 5 months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Aug. 18</i> 19 <i>66</i> to <i>Sept. 23</i> 19 <i>66</i> , that (I) <u>(we)</u> last saw the deceased alive on <i>Sept. 23</i> 19 <i>66</i> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <i>Nam Dooh Yang</i> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Sept. 23, '66</i>	
23C. PHYSICIAN'S NAME (Type) <i>NAM DOOH YANG</i> M.D.				23D. ADDRESS <i>Bon Secours Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-26-1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 26 1966</i>		25B. NAME OF REGISTRAR <i>R. G. E. Feltman</i>		25C. FUNERAL DIRECTOR <i>George J. Gonce - 4001 Ritchie Hwy.</i>		ADDRESS <i>Baltimore, Md. 21225</i>	

12/2/82

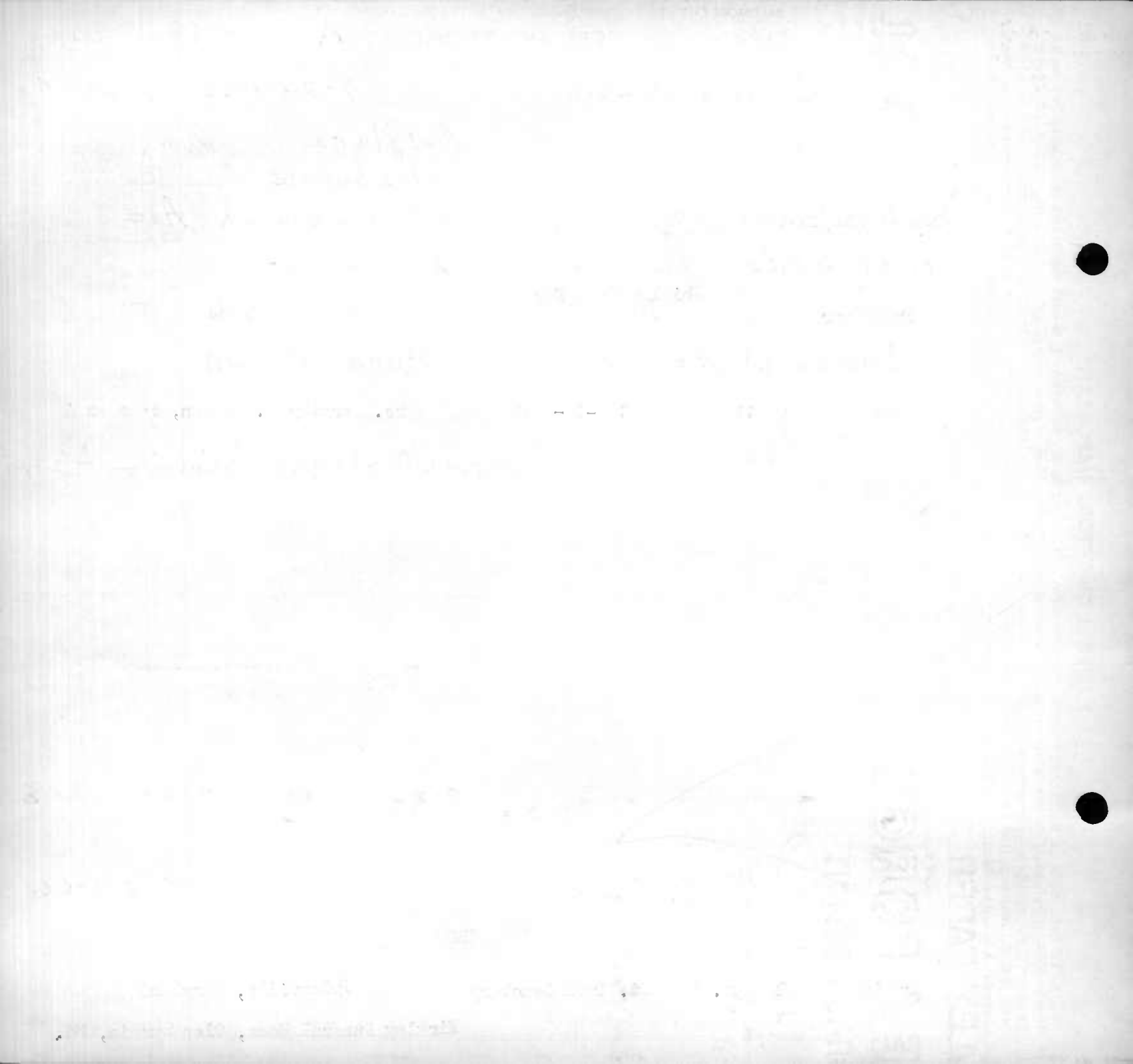
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09693	
BIRTH NO. 66 09693		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <i>Charles Heaton</i>		2. DATE AND HOUR OF DEATH <i>9-23-1966 1:00 P.M.</i>	
1. NAME OF DECEASED (Type or Print)					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hosp.</i>		A. STATE <i>Maryland</i> B. COUNTY <i>AA</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Glenburnie 62-00</i>			
		D. STREET ADDRESS (If rural, give location) <i>303 Glenwood Ave.</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>2-28-22</i>	9. AGE (In years last birthday) <i>44</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Shipley Transfer</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	
13. FATHER'S NAME <i>Charles W. Heaton</i>		14. MOTHER'S MAIDEN NAME <i>Anna Brown</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW 11</i>		16. SOCIAL SECURITY NO. <i>190-12-2220</i>		17. INFORMANT <i>Mrs. Dorothy L. Heaton, same as 4</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Myelogenous Leukemia 2 1/2 yrs</i>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 yrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>this</del> (this hospital) attended the deceased from <i>7-22</i> 19 <i>66</i> to <i>9-23</i> 19 <i>66</i> , that <del>we</del> (we) last saw the deceased alive on <i>9-23</i> 19 <i>66</i> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Beryl M. Swann</i> M.D.				23B. DATE SIGNED <i>9-23-66</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. <i>SBGH</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>26 Sept. 66</i>		24C. NAME of CEMETERY or CREMATORY <i>St. Paul Cemetery</i>	
24D. LOCATION <i>Pylesville, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 26 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Kirkley Funeral Home, Glen Burnie, Md.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

651286 09694		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09694	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
August U. Campagna		XXXX-24-66-11:30 PM		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours Hospital		A. STATE Maryland		B. COUNTY Harris	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Carroll County Md.	
		D. STREET ADDRESS (If rural, give location)		113 E Hemlock Dr 5600	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4/29/1913	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Special Policeman		Maryland Racing Commission		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Anthony Campagna		Vincenza --		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Pt's chart & son -	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420111		Acute Myocardial Infarction -			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
		CONGESTIVE HEART FAILURE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9/24/66 to 9/24/66, that (I) (we) last saw the deceased alive on 9/24/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
J. Malinski		9/25/66			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JAMES BRADY		Bon Secours Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-29-66		New Cathedral Cem.	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 26 1966		P. G. E. Taylor		Witzke F.D.-4101 Edmondson Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09695</b>	
BIRTH NO. <b>68 09695</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>WILSON, DOROTHY R. M.</b>		2. DATE AND HOUR OF DEATH <b>9-25-66 2:45A M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>25-31</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21229</b>			
		D. STREET ADDRESS (If rural, give location) <b>600 CHARRAWAY ROAD</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b>	8. DATE OF BIRTH <b>9-14-18</b>	9. AGE (In years last birthday) <b>48</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>ELMER RICKETTS</b>		14. MOTHER'S MAIDEN NAME <b>ANNA M KEELAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215014891</b>		17. INFORMANT ADDRESS <b>ST. AGNES RECORDS-CATON &amp; WILKENS AVES</b>	
18. <b>170X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic carcinoma of the breast</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 16 19 66</b> to <b>SEPTEMBER 25 1966</b> , that (I) (we) last saw the deceased alive on <b>SEPTEMBER 25 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John B. Herts M.D.</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9-25-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN B. HERTS,</b>		23D. ADDRESS <b>ST. AGNES HOSPITAL-CATON &amp; WILKENS AVE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-28-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Talley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke F.D.-4101 Edmondson Av.</b>			

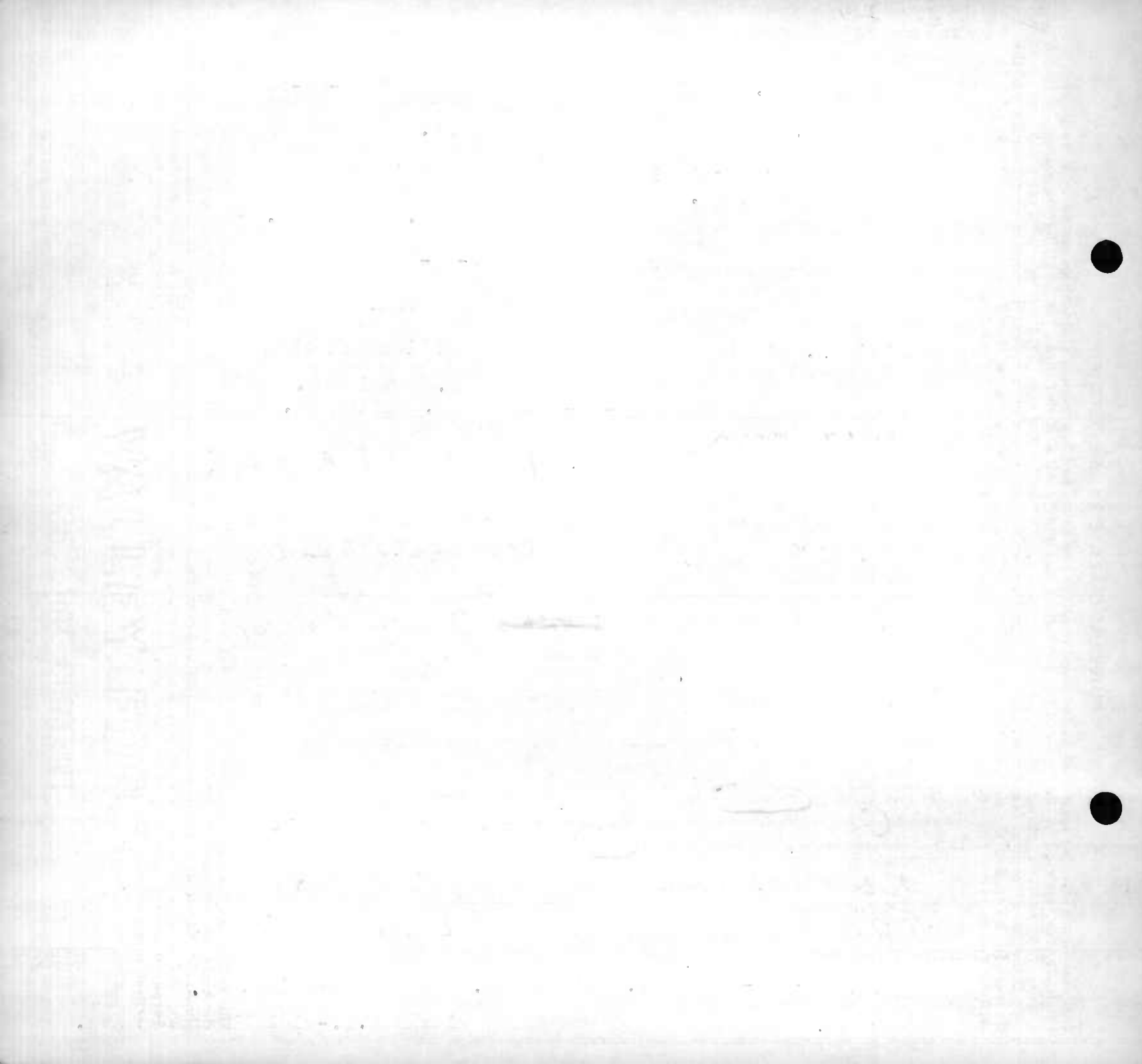
for members of the  
Board of

James D. Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. <b>66 09696</b>		CERTIFICATE OF DEATH		Registered No. <b>66 09696</b>	
1. NAME OF DECEASED (Type or Print) <b>Gladys S. Engle</b>				2. DATE AND HOUR OF DEATH <b>9-25-66</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Lutheran Hospital Baltimore, Md.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3 N. Hilton St.</b>			
5. SEX <b>F.</b>	6. RACE <b>Wh</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>7-20-10</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Calvin D. Steele</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Schecles</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>219-07-3533</b>		17. INFORMANT <b>Mr. Charles C. Engle</b>		ADDRESS <b>3 N. Hilton St.</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>420.14 1260X</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes Mellitus</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>September 22, 1966</b> to <b>September 25, 1966</b> , that (I) (we) last saw the deceased alive on <b>September 25, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Robert C. Blackmon</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/25/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert C. Blackmon,</b>				23D. ADDRESS <b>Lutheran Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-29-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olivet Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick, Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>Hubert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke F.D.-4101 Edmondson Ave.</b>			





47-77-27  
NW

C5050 66 09697

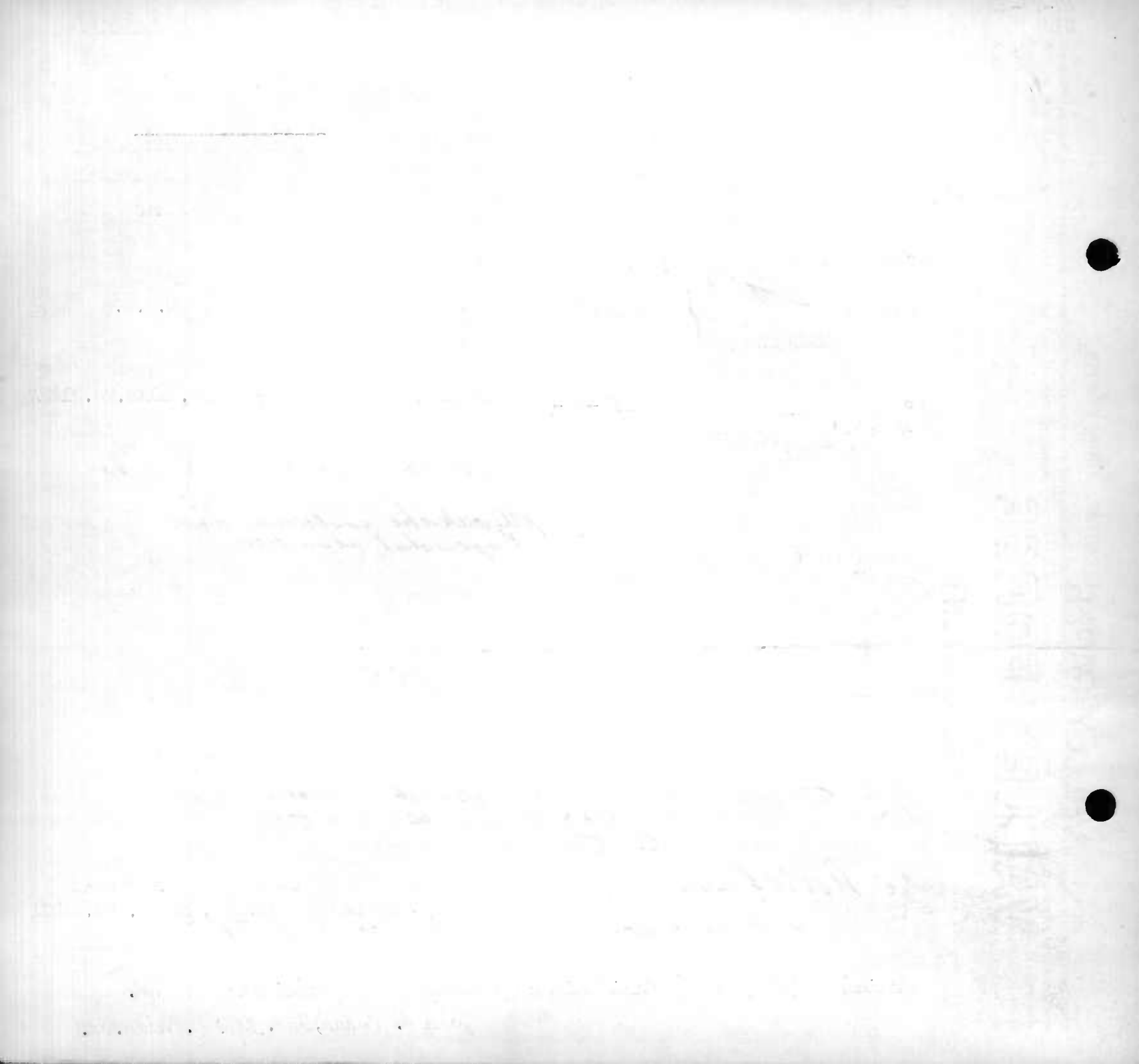
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 66 09697

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

1. NAME OF DECEASED (Type or Print) <b>Edward Phillip Ciano</b>		2. DATE AND HOUR OF DEATH <b>Sept. 23, 1966</b> <b>2 Noon</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE MARYLAND 21224</b>		4. USUAL RESIDENCE Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore County</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>604 Wyanoke Ave - 21218</b>	
5. SEX <b>Male</b>	6. RACE <b>Cau.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>7/2/07</b>
9. AGE (In years last birthday) <b>59</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-18-5699</b>	
17. INFORMANT <b>RECORDS: BCH 4940 Eastern Ave, Balto. Md. 21224</b>		ADDRESS	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>cardiac arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic cardiovascular disease ? 1 year &amp; myocardial infarction</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	
19. DATE OF OPERATION <b>2</b>		20. AUTOPSY? (Yes or No) <b>yes</b>	
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
23. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>While At Work</b>		24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
25. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		26. HOW DID INJURY OCCUR?	
27. I certify that (1) (this hospital) attended the deceased from <b>9/23/66</b> 19 <b>66</b> to <b>9/23</b> 19 <b>66</b> , that (2) (we) last saw the deceased alive on <b>9/23</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		28. SIGNATURE <b>e. P. Wilkinson</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
29. PHYSICIAN'S NAME (Type) <b>C. P. Wilkinson</b>		30. DATE SIGNED <b>9/23/66</b>	
31. ADDRESS <b>4940 Eastern Avenue, Balto. Md. 21224</b>		32. ADDRESS <b>Baltimore City Hospital</b>	
33. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		34. DATE <b>9/26/66</b>	
35. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		36. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
37. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		38. NAME OF REGISTRAR <b>Robert E. ...</b>	
39. FUNERAL DIRECTOR <b>John A. Moran, Inc. 3000 E. Balto. St.</b>		40. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 09698					REGISTERED NO. 66 09698				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <b>JOHN KARPOVICH</b>					2. DATE AND HOUR OF DEATH <b>9/24/66 2:05 P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>6-01</b>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Church Home &amp; Hospital</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>				
					D. STREET ADDRESS (If rural, give location) <b>10 N. POTOMAC ST.</b>				
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (specify)		8. DATE OF BIRTH <b>4/1/95</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator - hot rolls</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Revere Copper &amp; Brass</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WWI</b>				16. SOCIAL SECURITY NO. <b>216-03-0845</b>		17. INFORMANT <b>EDWARD KARPOVICH</b> ADDRESS <b>340 S. ROBINSON ST.</b>			
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0-</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>DOA 9/24/66</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Francisco Baltazar Jr.</b> M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/24/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>FRANCISCO BALTAZAR, JR.</b> M.D.						23D. ADDRESS <b>Church Home &amp; Hospital Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/28/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart of Jesus Cemetery, Baltimore, Md.</b>			24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>			25B. NAME OF REGISTRAR <b>R. B. E. Talley, M.D.</b>			25C. FUNERAL DIRECTOR ADDRESS <b>John A. Moran, Inc. 3000 E. Baltimore St.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>W 520-2250</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09699</b>	
M.E. CASE NO. <b>66 09699</b>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Weems, Margaret (Jackson)</b>		2. DATE AND HOUR OF DEATH <b>1:35 PM Sept. 24, 1966 M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>15-06</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>3008 HERBERT STREET</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>8/4/16</b>	9. AGE (In years last birthday) <b>50</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Md..</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIE WEEMS</b>			
14. MOTHER'S MAIDEN NAME <b>HATTIE CHAPMAN.</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hattie Weems Lutherville?, Md.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Dissecting aortic aneurysm</b>		19. CAUSE OF DEATH (A) DUE TO <b>hypertension and</b> (B) DUE TO <b>collagen vascular disease</b> (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, contributing to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>9/24/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>dissecting aortic aneurysm</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <b>8:00 PM 9/23 1966</b> to <b>1:35 PM 9/24 1966</b> , that (I) <u>(we)</u> last saw the deceased alive on <b>1:35 PM 9/24 1966</b> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <b>Richard G. Parry</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/24/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARD G. PARRY, MD.</b>		23D. ADDRESS <b>M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9/28/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Pleasant Rest</b>		24D. LOCATION (City, town, or county) (State) <b>Towson, Balto. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>	25B. NAME OF REGISTRAR <b>R. E. E. E. E.</b>	25C. FUNERAL DIRECTOR <b>Wm. P. Whitman</b>		ADDRESS <b>1701 M. C. Calhoun St. Balto. Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 09700	
BIRTH NO. 66 09700		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>JOSEPHINE SALIKER</b>		2. DATE AND HOUR OF DEATH <b>9/25/66 7:15 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. JOSEPH GENERAL HOSPITAL</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>27-44</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO</b>			
				D. STREET ADDRESS (If rural, give location) <b>3006 ECHODALE</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>widowed</b>		8. DATE OF BIRTH <b>4/17/90</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH JANOWSKI</b>				14. MOTHER'S MAIDEN NAME <b>MARIANA ASTRONKA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>JOAN YEAGLEY (granddaughter)</b>		ADDRESS	
18. <b>421.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Antic Valvular Stenosis</b> <b>severe</b> <b>Calapic Antic Valvulitis</b> <b>Bronchopneumonia</b> <b>Chronic pneumonitis</b>				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/13 1966</b> to <b>9/25 1966</b> , that (I) (we) last saw the deceased alive on <b>9/25 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Donald J. Gardner M.D.</b>				23B. DATE SIGNED <b>9/25/66</b>		23C. PHYSICIAN'S NAME (Type) <b>MD General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-29-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY ROSARY CEM</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>		25C. FUNERAL DIRECTOR <b>JOHN M. WEBER &amp; SONS INC 401 S CHESTER ST.</b>			

7.1.1

4/1/11

DEPARTMENT OF THE ARMY

WASHINGTON

TO General Joseph H. Gault

FROM Lieutenant

4/1/11

100

100

100

Marion Barron

100

100

4/1/11

100

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100



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S235

66 09701

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09701

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM MARCO SEXTON</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>September 25, 1966 4:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Harford</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Joppa</b> D. STREET ADDRESS (If rural, give location) <b>Route 1 Box 57 1210 Joppa Road</b>			
5. SEX <b>White</b>	6. RACE <b>Male</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 3, 1944</b>	9. AGE (In years last birthday) <b>22</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fork Lift Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>		11. BIRTHPLACE (State or foreign country) <b>Wytheville, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Grover Sexton</b>				14. MOTHER'S MAIDEN NAME <b>Margie I. Musser</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-40-8591</b>		17. INFORMANT ADDRESS <b>Joann E. Sexton, 1210 Joppa Road, Joppa, Md.</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple Traumatic Injuries</b> INTERVAL BETWEEN ONSET AND DEATH							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Route 40 Near Harford Co. line</b>			
21D. TIME OF INJURY (APPROX.) <b>9 25 '66 2:13 A.M.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Auto-Auto Accident Deceased - Driver</b>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) <b>Rudiger Breitenecker</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>9/25/66</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>Sept. 28, 1966</b>		23C. NAME OF CEMETERY or CREMATORY <b>Bel Air Memorial Gardens</b>		23D. LOCATION (City, town, or county) (State) <b>Bel Air Harford Co., Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		24B. NAME OF REGISTRAR <b>R. E. 2, Jr.</b>		24C. FUNERAL DIRECTOR ADDRESS <b>Howard K. McComas &amp; Son, Abingdon, Md. 21009</b>			

WALLINGFORD POLICE

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 66 09702	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
ARTHUR ALLEN POWELL				September 25, 1966 3:01 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Johns Hopkins Hospital				Maryland Harford			
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
				Magnolia			
				D. STREET ADDRESS (If rural, give location)			
				Fort Hoyle Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (in years lost birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
Male	White	Never Married	May 3, 1946	20			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Trimmer		Tree		Washington, D.C.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Arthur H. Powell				Kathleen Kiser			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no		216-48-1940		Arthur H. Powell, Fort Hoyle Rd, Magnolia, Md.			
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)							
(A) Multiple Traumatic Injuries							
DUE TO							
(B) DUE TO							
(C) DUE TO							
INTERVAL BETWEEN ONSET AND DEATH							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
		Street		Route 40 near Harford Co. line			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
9 25 '66 2:13 A.M.		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Auto-Auto Accident Deceased - Passenger			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
Rudiger Breitenecker				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		9/25/66	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		Sept. 27, 1966		Bel Air Memorial Gardens		Bel Air Harford Co., Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS			
SEP 26 1966		G. E. [Signature]		Howard K. McComas & Son, Abingdon, Md. 21009			

WALKLEY FOLIO

WALKLEY FOLIO

WALKLEY FOLIO

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09703	
BIRTH NO. 66 09703					
M.E. CASE NO. 66 09703					
1. NAME OF DECEASED (Type or Print) <b>EMMA SANDERS</b>			2. DATE AND HOUR OF DEATH <b>9/25/66 1:30 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>10-5-66 Midtown Nursing Home</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>10-01</b>		
5. SEX <b>F</b>			6. RACE <b>C.</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		8. DATE OF BIRTH <b>7/26/09</b>
13. FATHER'S NAME <b>RICHARD THOMAS</b>			14. MOTHER'S MAIDEN NAME <b>MATILDA MILLER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		9. AGE (In years last birthday) <b>57</b>
17. INFORMANT <b>Robert Sanders 1107 E. Preston St</b>			ADDRESS		
18. <b>170X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO <b>Carcinoma Left Breast</b> (B) DUE TO <b>Metastasis - Generalized</b> (C) _____		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>Arteriosclerotic Cardiovascular Disease ?</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/21 1966</b> to <b>9/25 1966</b> , that (I) (we) last saw the deceased alive on <b>9/21 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph S. Blum M.D.</b>				23B. DATE SIGNED <b>9/26/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH S. BLUM M.D.</b>				23D. ADDRESS <b>1115 N. CALVERT ST</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/29/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Pk.</b>	
24D. LOCATION (City, town, or county) <b>Arbutus Mem. Pk.</b>		(State) _____		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>	
25B. NAME OF REGISTRAR <b>Robert E. Sanders</b>		25C. FUNERAL DIRECTOR <b>Joseph E. Lockyer</b>		ADDRESS <b>1304 N. Central Ave</b>	

Letter from Attending Physician  
10-5-66 M.H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 09704	
BIRTH NO. 66 09704											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <b>FRUMENTIUS JOHNSON</b>						2. DATE AND HOUR OF DEATH <b>9/25/66 6.10 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL</b>						A. STATE <b>MD</b> B. COUNTY <b>1403</b>					
(If not in hospital or institution, give street address or location)						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>					
						D. STREET ADDRESS (If rural, give location) <b>1903 Mc CULLCH ST #17</b>					
5. SEX <b>M</b>		6. RACE <b>N</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W</b>		8. DATE OF BIRTH <b>10/21/87</b>		9. AGE (In years last birthday) <b>78</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>professional blacksmith</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>blacksmith</b>				11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>THOMAS</b>						14. MOTHER'S MAIDEN NAME <b>REBECCA</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>DAUGHTER - ELIZABETH MANOKEY</b>				ADDRESS	
18. <b>153.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMA of INTESTINE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH <b>1903 Mc CULLCH</b>		INTERVAL BETWEEN ONSET AND DEATH <b>#17 4 months</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>—</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>				20A. AUTOPSY? (Yes or No) <b>PARTIAL</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/4</b> 19 <b>66</b> to <b>9/25</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>9/25</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Eduardo Hidalgo</b>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>EDUARDO HIDALGO</b>						23D. ADDRESS <b>SINAI HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/28/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>new Cathedral</b>				24D. LOCATION (City, town, or county) (State) <b>Balt. MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>				25B. NAME OF REGISTRAR <b>Robert E. ...</b>				25C. FUNERAL DIRECTOR <b>Joseph D. Rock</b>			
						ADDRESS <b>1304 N. Central Ave</b>					

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09705				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09705	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>LEONIA MONROE</b>				2. DATE AND HOUR OF DEATH <b>9-22-66 8:40 P</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
<b>Johns Hopkins Hospital</b>				<b>922 N. CASTLE ST.</b>		<b>7-04</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				<b>Baltimore, Maryland</b>			
				D. STREET ADDRESS (If rural, give location)			
5. SEX <b>F</b>		6. RACE <b>N</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>NOV 27 - 1906</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) <b>65</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
<b>Housewife</b>						12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Johns Monroe</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Miltner</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Frank Monroe 1030 Wabash St</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac arrest</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>10 mins</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <b>9/22</b> 19 <b>66</b> to <b>9/22</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/22</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Robert M. Winslow</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/23/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert M. Winslow</b>				23D. ADDRESS <b>Johns Hopkins Hospital, Balt. Md.</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-26-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cent</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Choy Wilson 1000 Brantley Rd</b>		ADDRESS	



66 09708  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09708

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES

MEISTER

2. DATE AND HOUR PRONOUNCED DEAD

September 23, 1966

2:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

224 Beale Court

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

224 Beale Court

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

10-14-1881

9. AGE (in years  
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Cahoon, Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Elizabeth Meister

ADDRESS

Lancaster

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Carcinomatosis (primary ?)  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/24/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9-28-66

23C. NAME OF CEMETERY or CREMATORY

Mt Airy Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md

24A. DATE REC'D BY HEALTH DEPT.

SEP 26 1966

24B. NAME OF REGISTRAR

G. E. E. E. E.

24C. FUNERAL DIRECTOR

Eloyd Wilson 1000 Brantley Dr

ADDRESS

VALLEY FENCE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09707</u>	
BIRTH NO. <u>08707</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>08707</u>		1. NAME OF DECEASED (Type or Print) <u>WILLIE FRANKLIN JOHNSON</u>		2. DATE AND HOUR OF DEATH <u>9/22/66 17:55 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>VIRGINIA</u> B. COUNTY <u>ALEXANDRIA</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>ALEXANDRIA</u> D. STREET ADDRESS (If rural, give location) <u>738 N - Columbus ST</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>6/21/61</u>	9. AGE (In years last birthday) <u>5</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>FRANKLIN JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Johnson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MOTHER</u> ADDRESS <u>as above</u>	
18. <u>734.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY HYPERTENSION</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CONGENITAL HEART DISEASE (VSD, ASD, PDA, Hypoplastic Aortic Arch)</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 4/12 yrs</u> <u>5 4/12 yrs.</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>FEBRUARY</u> 19 <u>63</u> to <u>SEPTEMBER</u> 19 <u>66</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>9/22</u> 19 <u>66</u> and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Allen H. Neims</u> M.D.				23B. DATE SIGNED <u>9/22/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Allen H. Neims</u>		23D. ADDRESS <u>The Johns Hopkins Hospital</u> M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9/27/66</u>	24C. NAME OF CEMETERY or CREMATORY <u>Douglas</u>	24D. LOCATION (City, town, or county) (State) <u>Alexandria Va.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Tolson</u>		25C. FUNERAL DIRECTOR <u>R.H. Spole</u> ADDRESS <u>311 N Patrick Alex 7th</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09708</b>	
BIRTH NO. <b>R360</b>		M.E. CASE NO. <b>66 09708</b>		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>DAVID REEDER</b>			2. DATE AND HOUR OF DEATH <b>9/26/66</b>   <b>2<sup>15</sup></b> <b>A</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>			A. STATE <b>Maryland</b> B. COUNTY <b>8-06</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 13</b>		
			D. STREET ADDRESS (If rural, give location) <b>1617 - Chapel St</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>11-2-36</b>	9. AGE (In years lost birthday) <b>29</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Glenn Parker Lane</b>
18. <b>422.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiomyopathy</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>retial</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>7 years</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/21</b> 19 <b>66</b> to <b>9/26</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>9/26</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. Rampton</b>				23B. DATE SIGNED <b>9/26/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>R. Rampton</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-29-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore Cent</b>	
24D. LOCATION <b>Baltimore</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>Glenn E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Clayton Wilson / Mrs. Brantley Lee</b>	

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100-1000  
100-1000

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11-23-24



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 09709		CERTIFICATE OF DEATH		Registered No. 66 09709	
1. NAME OF DECEASED (Type or Print) <b>CLARENCE TILLERY</b>				2. DATE AND HOUR OF DEATH <b>Sept. 22, 1966 7:40 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>10-6-66 church home + hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>1516 N. AISQUITTH STREET ZONE 19x 21202</b> B. COUNTY <b>BALTIMORE, MARYLAND</b>					
5. SEX <b>M</b>				6. RACE <b>C</b>		7. MARRIED, <del>NEVER MARRIED</del> WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>1-3-1936</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ALBERT TILLERY</b>				14. MOTHER'S MAIDEN NAME <b>LILLIAN BROWN</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Albal Tillery 27 Edgewood St</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>493X I</b>				CAUSE OF DEATH (A) <b>Azotemia due to acute tubular necrosis?</b> (B) <b>Paralytic illness due to peritonitis.</b> (C) <b>Bilateral pneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>				Fatty infiltration of liver.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 20 19 66</b> to <b>Sept. 22 19 66</b> , that (I) (we) last saw the deceased alive on <b>Sept. 22 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>A. Hahn</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>ALBERT T MENITA</b>				23D. ADDRESS <b>SUREZ M.D. CHURCH HOME &amp; HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>9-26-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt Calvary Art</b>		24D. LOCATION (City, town, or county) (State) <b>Burke's Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>J. E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Chas Wilson</b>		ADDRESS <b>1000 Brantley Rd</b>			

Letter from Church Home and Hospital  
10-6-66 M.H.

RECEIVED DIRECT

Stingfield + South

H

G

20X

D

24th 25th 26th

Stingfield

ATLANTA

30th 31st

CHURCH

HOME

HOSPITAL

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WARREN D. SMITH

2. DATE AND HOUR PRONOUNCED DEAD

September 25, 1966 10:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

STREET ADDRESS (If rural, give location)

770 Cranston Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

12/9/47

9. AGE (In years  
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Roosevelt Smith

14. MOTHER'S MAIDEN NAME

Margaret Randell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Ms Margaret Randell 770 Grantley St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Gunshot wound of back  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Preston and Etting Streets

21D TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.) 9-25-66 10:15 P.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK21F. HOW DID INJURY OCCUR? Shot by off duty police  
officer after purse snatching

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 26, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9/30/66

23C. NAME of CEMETERY or CREMATORY

Mt Galvary Cemetry

23D. LOCATION

(City, town, or county)

A A County Md

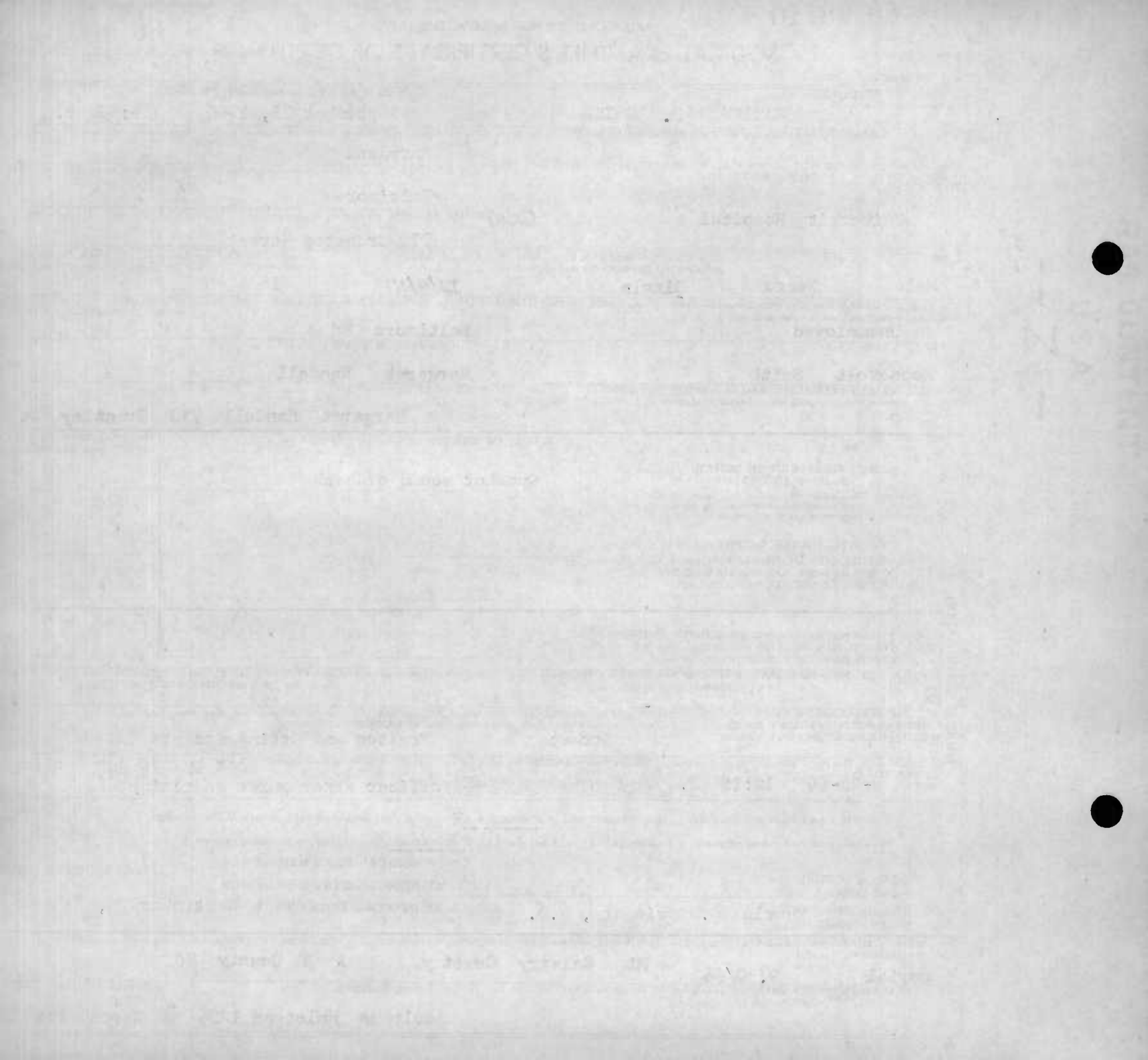
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Ave



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09711		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09711	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Elmer L. Smith		2. DATE AND HOUR OF DEATH 25 Sept 1966 10:20 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Balt. city		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital		D. STREET ADDRESS (If rural, give location) 209 Woodyear St		19-02	
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 3/3/03	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Wimberly Smith		14. MOTHER'S MAIDEN NAME Nettie Collier	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO.		17. INFORMANT hospital records	
18. 445 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Uremia DUE TO (B) Malignant hypertension DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 mo ? 2 mo	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 9/16/1966 to 9/25/1966, that (we) last saw the deceased alive on 9/25/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Susan L. Howard M.D.		23B. DATE SIGNED 9/25/66		23C. PHYSICIAN'S NAME (Type) M.D. University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/30/66		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md		25A. DATE REC'D BY HEALTH DEPT. SEP 26 1966		25B. NAME OF REGISTRAR Adolphus Halstead	
25C. FUNERAL DIRECTOR Adolphus Halstead		25D. ADDRESS 1206 W North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <b>66 09712</b>	
BIRTH NO. <b>66 09712</b>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Charles Walter Garber</b>		2. DATE AND HOUR OF DEATH <b>9/19/66</b> <b>2:05</b> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>LUTHERVILLE, Maryland</b> D. STREET ADDRESS (If rural, give location) <b>Box 185</b> <b>5300</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>2/22/92</b>		9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Tire Symington</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Not Known</b>				14. MOTHER'S MAIDEN NAME <b>Not Known</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Not known</b>		17. INFORMANT <b>Patient's chart</b>		ADDRESS	
18. <b>420.141260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY Edema</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial Infraction</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <b>Myocardial Infraction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6-8 hrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes Mellitus</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (he) (this hospital) attended the deceased from <b>9/19</b> <b>1966</b> to <b>9/19</b> <b>1966</b> , that (we) lost saw the deceased alive on <b>9/19</b> <b>1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John R. Vaughn Jr.</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/19/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN R. VAUGHN, JR.</b>				23D. ADDRESS M.D. <b>THE UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town or county) (State)	
<b>Burial</b>		<b>SEP 26 1966</b>		<b>St. Mary's Cemetery</b>		<b>Pitersville 8, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<b>SEP 26 1966</b>		<b>Robert E. Taylor</b>		<b>Frank H. Jewell</b>		<b>Pitersville 8, Md.</b>	



THE AMERICAN HOSPITAL

JOHN D. VAUGHN, JR.



H630

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 66 09713		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09713	
1. NAME OF DECEASED (Type or Print) WILLIAM J. HURD		2. DATE AND HOUR PRONOUNCED DEAD September 23, 1966 6:15 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2573 McCulloh Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2573 McCulloh Street 13-03	
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH June 6, 1908
9. AGE (In years last birthday) 58		10. BIRTHPLACE (State or foreign country) Fairfield, Md.	
11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Hurd		14. MOTHER'S MAIDEN NAME Jennie Ford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. William Hurd - 2573 McCulloh St	
17. INFORMANT William Hurd		ADDRESS 2573 McCulloh St	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker,		CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] ASSOCIATE MEDICAL EXAMINER [ ] DATE SIGNED 9/24/66	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE Sep. 28, 1966	
23C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem		23D. LOCATION (City, town, or county) (State) Westport, Md.	
24A. DATE REC'D BY HEALTH DEPT. SEP 26 1966		24B. NAME OF REGISTRAR E. E. [ ]	
24C. FUNERAL DIRECTOR		ADDRESS 1297 N. Caroline St	

17

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Jan 6 1907

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James Smith

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17 17

James Smith

17 17

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BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED

(Type or Print)

RICHARD

CAREY

2. DATE AND HOUR PRONOUNCED DEAD

September 23, 1966

7:55 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

John Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2123 E. Federal Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Nov 1, 1921

9. AGE (In years  
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lynchburg Va.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Edward Carey

14. MOTHER'S MAIDEN NAME

Margaret Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Raymond Carey 2123 E. Federal St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Stabwound of neck  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

home

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

2052 E. Hoffman Street

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

9-23-66 7:25 A

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Deceased stabbed self in neck

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 23, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Sept 28 / 66

23C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park

23D. LOCATION

(City, town, or county)

Arbutus Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 26 1966

24B. NAME OF REGISTRAR

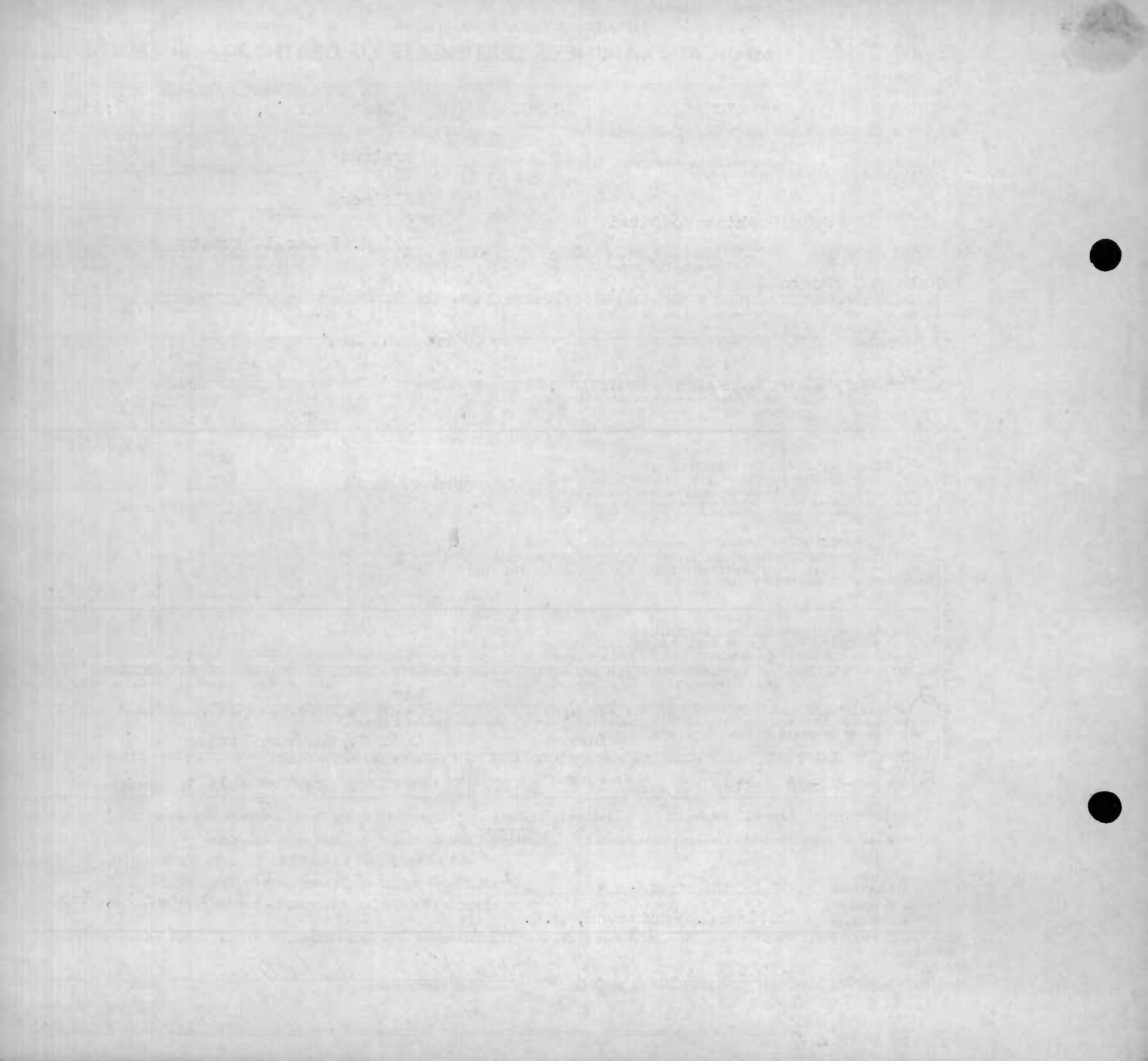
G. E. 2. Bailey, M.D.

24C. FUNERAL DIRECTOR

Wilton E. Clarkson

ADDRESS

1129 N. Caroline St



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09715				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 09715	
1. NAME OF DECEASED (Type or Print) <i>Ida Smith</i>				2. DATE AND HOUR OF DEATH <i>Sept. 24, 1966</i>   <i>6 15</i> A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University of Maryland Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>25-32</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i> D. STREET ADDRESS (If rural, give location) <i>2725 Carver Rd.</i>					
5. SEX <i>M.</i>	6. RACE <i>Coloured</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>June 6, 1899</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Adam Watson</i>				14. MOTHER'S MAIDEN NAME <i>Alice Watkins</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Charlotte Hurtt</i>				
18. <i>331X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Congestive Heart Failure, Bronchopneumonia</i> <i>Myocardial Infarction</i>				CAUSE OF DEATH (A) <i>Cerebral Hemorrhage</i> DUE TO (B) <i>Atherosclerosis</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>Several years</i> <i>2 weeks</i> <i>Several mos.</i>			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>Sept. 21</i> 19 <i>66</i> to <i>Sept. 24</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Sept. 24</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Richard H. Anderson</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Sept. 24, 1966</i>			
23C. PHYSICIAN'S NAME (Type) <i>Richard H. Anderson</i>				23D. ADDRESS M.D. <i>University Hospital Baltimore, Md.</i>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Sept. 29, 1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arboretum Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Westport, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 26 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Sisk</i>		25C. FUNERAL DIRECTOR <i>Milton E. Elcherson</i>					
				ADDRESS <i>1129 N. Carolina</i>					

Mr. Robert M. Adams  
President  
Columbia Station  
New York

My dear Sir  
I have the honor to  
acknowledge the receipt of  
your letter of the 27th  
inst. in relation to the  
Columbia Station.

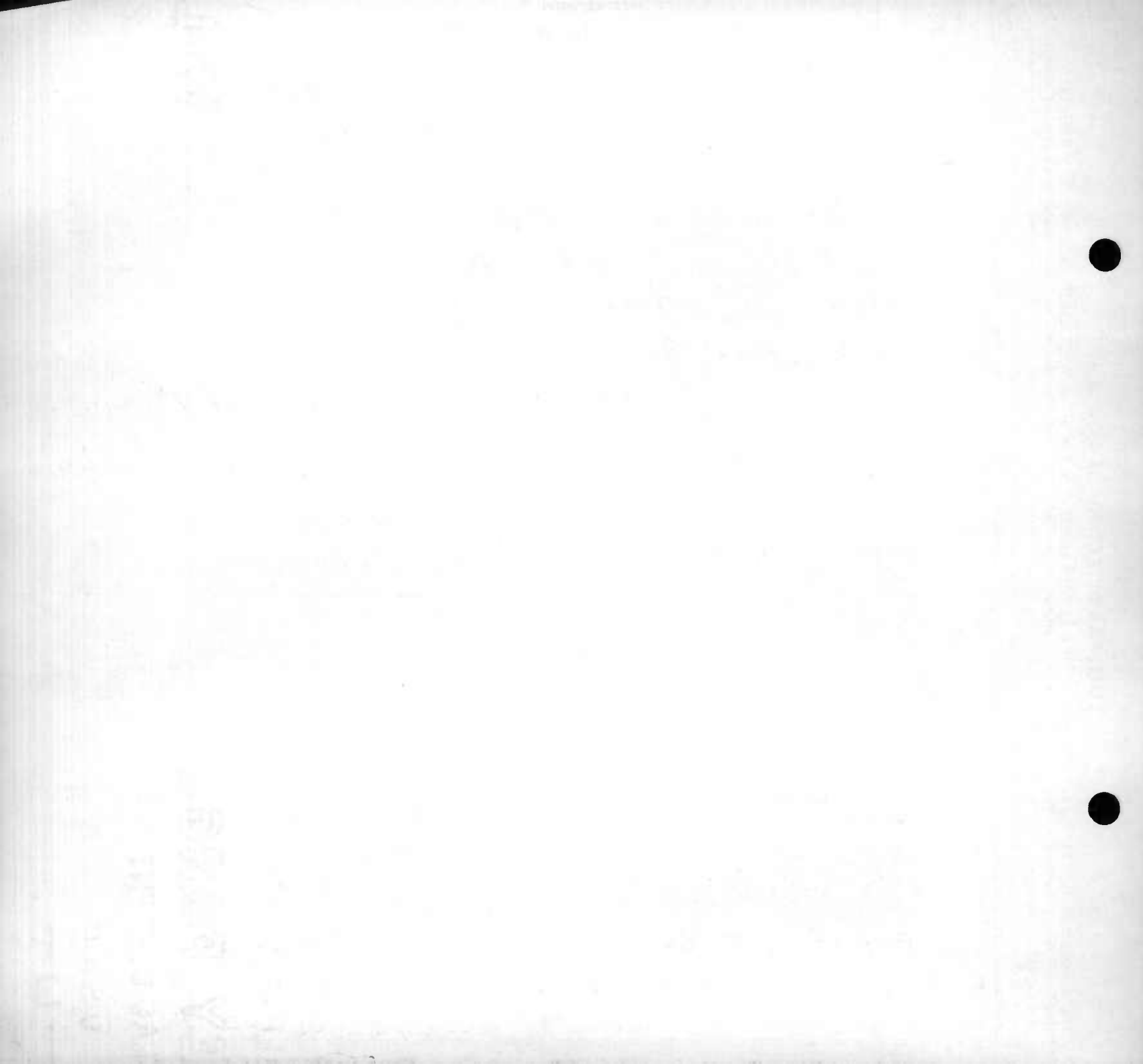
I am sorry to hear that  
you are not satisfied with  
the service rendered by  
the Columbia Station.  
I will endeavor to  
improve the service  
and will be glad to  
hear from you again.  
Very respectfully,  
Your obedient servant,  
John W. Adams



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 09716</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09716</b>	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Clara Hyman</b>			2. DATE AND HOUR OF DEATH <b>9-25-66 13:00 P. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>South Baltimore General Hosp.</b>			A. STATE <b>Maryland</b> B. COUNTY <b>13-03</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>2637 Francis St.</b>		
5. SEX <b>F.</b>	6. RACE <b>Negro.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>10-2-1898</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nail</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <b>Henry Gross (AKA) Smith</b>			14. MOTHER'S MAIDEN NAME <b>Clara Gross</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>220-24-8624</b>		17. INFORMANT ADDRESS <b>Augustus Rustino 2637 Francis St.</b>
18. <b>15-3-31</b>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) <b>Gran Negative Septicemia</b>		
ANTECEDENT CAUSES			(B) <b>Pelvic Abscess</b>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) <b>Carcinoma of Sigmoid Colon</b>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>9-19 1966</b> to <b>9-25 1966</b> , that (we) last saw the deceased alive on <b>9-25 1966</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Berestford M. Swan</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9-26-1966</b>
23C. PHYSICIAN'S NAME (Type) <b>Berestford M. Swan</b>			23D. ADDRESS <b>South Baltimore General Hosp.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9-30-66</b>	24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem Clay</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Joseph L. Rawn 2222 W North Ave</b>	





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66 09717

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09717

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **JAMES Dennis Austin** 2. DATE AND HOUR PRONOUNCED DEAD **9/6/66 12:01 p. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

A. STATE **Maryland** B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) **Baltimore 12-65**

5. SEX **male** 6. RACE **white** 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) **SINGLE** 8. DATE OF BIRTH **9-28-1923** 9. AGE (In years last birthday) **42** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) **BUNCOMBE CO. NORTH CAROLINA** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **EUGENE AUSTIN** 14. MOTHER'S MAIDEN NAME **ESPIE WEST**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **YES W W II NAVY** 16. SOCIAL SECURITY NO. 17. INFORMANT **MRS. ETHEL CALLOWAY, 228 WAYNESVILLE AVENUE** ADDRESS

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

**Fatty alteration of liver** (A) DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **partial** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

**Werner U. Spitz, M.D.**

CHIEF MEDICAL EXAMINER ☐ M.D. ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

**9/6/66**

23A. BURIAL CREMATION, REMOVAL (Specify) **BURIAL** 23B. DATE **9-9-66** 23C. NAME OF CEMETERY or CREMATORY **PEEKS CEMETERY** 23D. LOCATION (City, town, or county) (State) **MADISON COUNTY, NORTH CAROLINA**

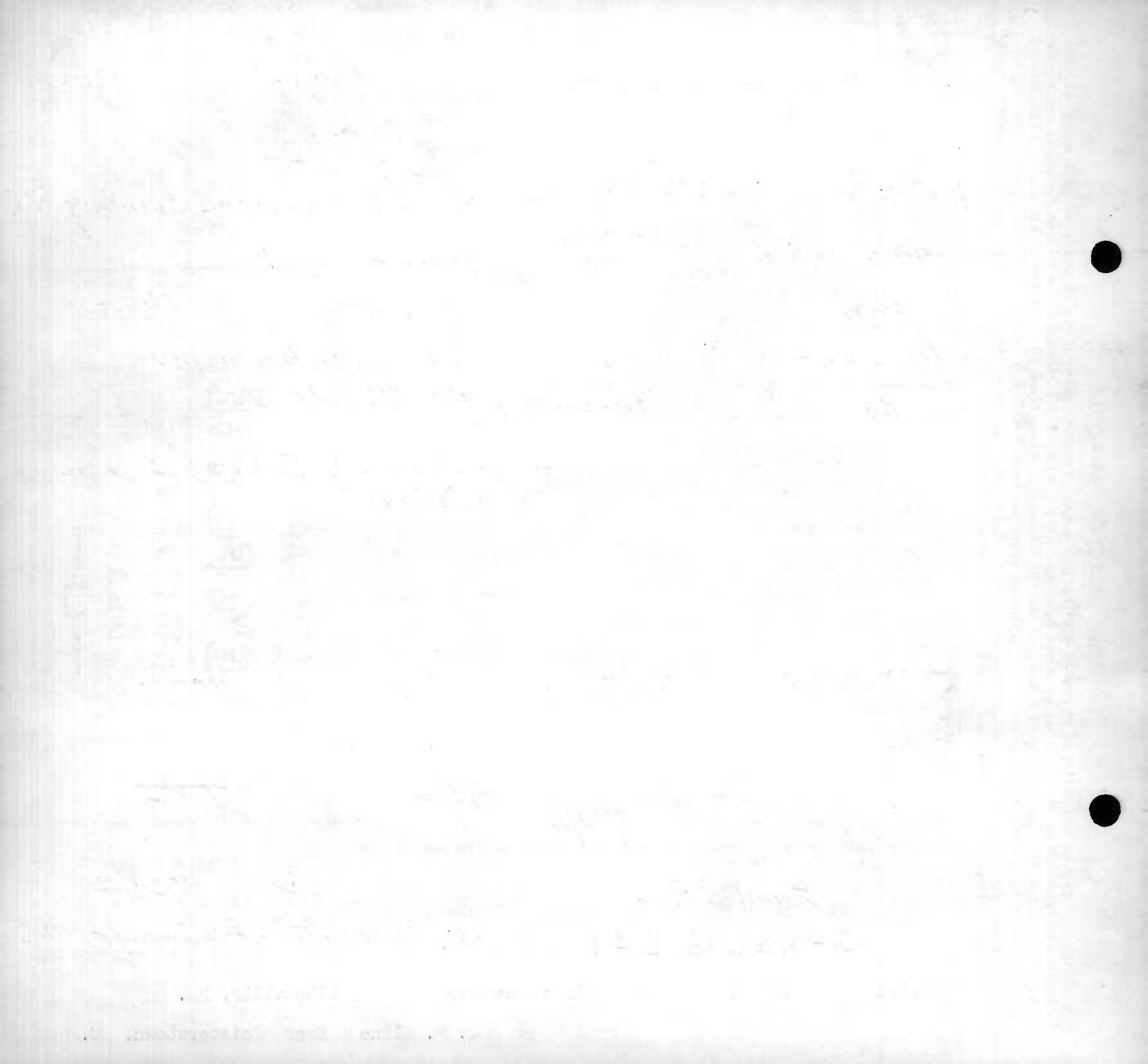
24A. DATE REC'D BY HEALTH DEPT. **SEP 26 1966** 24B. NAME OF REGISTRAR **A. E. Farley, M.D.** 24C. FUNERAL DIRECTOR **HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29** ADDRESS

WALLACE HODGE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09718		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09718	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Niemeyer, George H.</i>		2. DATE AND HOUR OF DEATH <i>9/24/66 12:50 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Carroll</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Westminster 3627</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Montebello State Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>90 Mrs. Lee Marie Houff, Cranberry Rd</i>			
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, <u>DIVORCED</u> (specify)	8. DATE OF BIRTH <i>3/18/1902</i>	9. AGE (In years last birthday) <i>64</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William Henry Niemeyer</i>		14. MOTHER'S MAIDEN NAME <i>Caroline K. Baumann</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-28-7264</i>		17. INFORMANT ADDRESS <i>Hospital Records</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Hypernephroma of rt. kidney 2 years.</i> <i>c metastasis</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2 Dec. 1965</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>exploratory</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>5/15/66</i> 19 to <i>9/24/66</i> 19, that (I) (we) last saw the deceased alive on <i>9/24/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Daniel F. Lai</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9/24/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>DANIEL G. LAI</i>		23D. ADDRESS M.D. <i>2201 Avenue Drive, Baltimore 18, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/28/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>SEP 25 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR <i>J. F. Eline &amp; Sons</i>		ADDRESS <i>Reisterstown, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Wengrow, Sylvia P.		9/23/66 4 <sup>10</sup> PM.	
3. PLACE OF DEATH (In Baltimore, Maryland)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224 Baltimore City Hosp.				A. STATE Md MARYLAND, PASADENA C. CITY OR TOWN (If outside city limits, write RURAL and give township) RT. 5 Box 42 Pasadena D. STREET ADDRESS (If rural, give location) RT. 5 Box 42 5200	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 5-31-26	9. AGE (In years last birthday) 40
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY @ home		11. BIRTHPLACE (State or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank PARSCHAL		14. MOTHER'S MAIDEN NAME Pearl McCREARY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 417161968		17. INFORMANT RECORDS: BALTIMORE CITY HOSPITALS #21224 4940 EASTERN AVENUE BALTIMORE, MD.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH 2-3 days 1 yr.	
19A. DATE OF OPERATION 9/23/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 9/22/66 19 66 to 9/23/66 19 66, that (1) (we) last saw the deceased alive on Sept 23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mary Ann Sullivan M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 9/23/66	
23C. PHYSICIAN'S NAME (Type) Mary Ann Sullivan M.D.		23D. ADDRESS 4940 EASTERN AVENUE BALTO., MD. #21224 Baltimore City Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/27/66		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem	
24D. LOCATION Baltimore		24E. LOCATION (City, town, or county) Baltimore		24F. LOCATION (State) Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 26 1966		25B. NAME OF REGISTRAR Robert S. Barranco		25C. FUNERAL DIRECTOR ADDRESS ROBERT S. BARRANCO	

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Presented to  
the

Library of the  
University of

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1873

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09720</u>	
BIRTH NO. <u>66 09720</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Potter, Nathaniel D.</u>		2. DATE AND HOUR OF DEATH <u>Sept 22, 1966. 9.25 AM.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <u>The Union Memorial Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>12-01</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>3526 Greenmount Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u> <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>10-01-85</u>	9. AGE (In years lost birthday) <u>80</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MECHANICAL ENGR. - BLACK &amp; DECKER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>William S. Potter</u>		14. MOTHER'S MAIDEN NAME <u>Carolyn Reeves</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT <u>Helen W. Potter</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>12:30 AM 09-07</u> 19 <u>66</u> to <u>09-22</u> 19 <u>66</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>09-22</u> 19 <u>66</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>We</u> ) ( <u>did</u> ) (did not) view the body after death.					
23A. SIGNATURE <u>Sang Won Song</u>				23B. DATE SIGNED <u>9-22/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. SANG WON SONG</u>				23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/26/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Spring Hill</u>	
24D. LOCATION <u>Easton,</u>		24E. LOCATION (City, town, or county) (State) <u>Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1966</u>		25B. NAME OF REGISTRAR <u>R. B. F. F. F.</u>		25C. FUNERAL DIRECTOR <u>Newnam &amp; Sons</u>	
25D. ADDRESS <u>Harrison St. Easton, Md.</u>					



10-10-10

RECEIVED

My dear Sir,

Yours

THE UNIVERSITY OF

10-10-10



Approved by Medical Examiner  
FUNERAL DIRECTOR: IMPORTANT  
To be

This certificate must be approved by the chief medical examiner of his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09721		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09721	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No. 66 09721	
1. NAME OF DECEASED (Type or Print) ANTHONY V. VECE		2. DATE AND HOUR OF DEATH September 23, 1966 6 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, 21224, Md.		A. STATE Md. B. COUNTY Baltimore 26-07			
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH Nov. 17, 1905		9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy		13. FATHER'S NAME Pasquale Vece	
14. MOTHER'S MAIDEN NAME Virginia Trotta		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. N.D.	
17. INFORMANT Mary E. Vece		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, ashenio, etc. It means the disease injury or complication which caused death.)		19. INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		21. CAUSE OF DEATH (A) Due to (B) Due to (C) Due to		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
23. DATE OF OPERATION		24. CONDITION FOR WHICH OPERATION WAS PERFORMED		25. AUTOPSY? (Yes or No) No	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
29. TIME OF INJURY (APPROX.)		30. INJURY OCCURRED		31. HOW DID INJURY OCCUR?	
32. I certify that (I) (this hospital) attended the deceased from 1960 to 9, 28, 1966, that (I) (we) last saw the deceased alive on NOV 26, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		33. SIGNATURE Ernest G. Marr		34. DATE SIGNED	
35. PHYSICIAN'S NAME (Type) Ernest G. Marr		36. ADDRESS 516 Cathedral St. Balto., Md.		37. DATE SIGNED	
38. BURIAL CREMATION, REMOVAL (Specify) Burial		39. DATE 9-26-66		40. NAME of CEMETERY or CREMATORY Sacred Heart Cem.	
41. DATE REC'D BY HEALTH DEPT. SEP 26 1966		42. NAME OF REGISTRAR Robert E. Jenkins, M.D.		43. FUNERAL DIRECTOR Charles S. Geiler	
44. ADDRESS 901 S. Conkling St BALTO., 21224, MD.		45. ADDRESS		46. ADDRESS	

Figure 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09722</u>	
BIRTH NO. <u>66 09722</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>GONCE, WILLIAM K.</b>		2. DATE AND HOUR OF DEATH <b>9-25-66 12:45A M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <u>Baltimore</u>			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL EMERGENCY ROOM</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>SIMPSONVILLE</b> D. STREET ADDRESS (If rural, give location) <u>4300</u>			
5. SEX <b>MALE</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>May 5, 1896</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>		11. BIRTHPLACE (State or foreign country) <b>Tenn</b>	
13. FATHER'S NAME <b>Hezekiah Gonce</b>			14. MOTHER'S MAIDEN NAME <b>Martha Collins</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-32-5216</b>		17. INFORMANT ADDRESS <b>ST. AGNES RECORDS - CATON &amp; WILKENS AVES</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.) <b>Complete heart block.</b>		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <b>Myocardial Infarction</b>			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 25 1966</b> to <b>SEPTEMBER 25 1966</b> , that (I) (we) last saw the deceased alive on <b>SEPTEMBER 25 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Rabhael Marin</i>				23B. DATE SIGNED <b>9/25/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>RABHAEL MARIN</b>		23D. ADDRESS M.D. <b>ST. AGNES HOSPITAL-CATON &amp; WILKENS AVES</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-28-1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Johns</b>	
24D. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <i>John E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>F.C. Higinbotham</i>	
				ADDRESS <b>Ellicott City, Md</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09723				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09723	
1. NAME OF DECEASED (Type or Print) <b>BYRD MARY R.</b>				2. DATE AND HOUR OF DEATH <b>Sept. 24, 1966 3:25 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Franklin Square Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Harford</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>JOPPA</b>			
				D. STREET ADDRESS (If rural, give location) <b>402 Braxton Court</b>			
5. SEX <b>F</b>	6. RACE <b>White</b>	7. <del>MARRIED</del> , NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>Aug. 23, 34</b>	9. AGE (In years last birthday) <b>32</b>	10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bendix</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Assembly</b>		11. BIRTHPLACE (State or foreign country) <b>Caryville, Tenna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Dave Elkins</b>				14. MOTHER'S MAIDEN NAME <b>Edna Miller</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>411-50-2361</b>		17. INFORMANT <b>Mr Floyd Byrd 402 Braxton Court Joppa</b>		ADDRESS	
18. <b>330 X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO <b>Aneurysm of left internal carotid artery with</b> (B) DUE TO <b>rupture into ventricular</b> (C) <b>systemic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>27 days</b>	
19A. DATE OF OPERATION <b>Sept. 21, '66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 7, 1966</b> to <b>Sept. 24, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept. 24, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Sang Bal He,</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Sept. 24, '66</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-28-1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Jacksboro Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Jacksboro, Tennessee</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>R. E. E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belton Road</b>		ADDRESS (36)	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09724</u>	
BIRTH NO. <u>66 09724</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <u>LEONARD JENKINS</u>		2. DATE AND HOUR OF DEATH <u>9-23-66</u> <u>7:45 P.M.</u>	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME &amp; HOSPITAL</u> <u>BALTIMORE, MARYLAND</u>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>19-02</u>	
				D. STREET ADDRESS (If rural, give location) <u>17 VINCENT AVE (21)</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>7-4-24</u>	9. AGE (In years last birthday) <u>42</u>	(If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRESSMAN, NATIONAL Can Mfg. Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>NEWTON JENKINS</u>		14. MOTHER'S MAIDEN NAME <u>ELWA KELLISON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-22-6118</u>		17. INFORMANT <u>PATIENT</u>	
18. <u>765 X 1</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>8/7/66 - 9/23/66</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury at complication which caused death.)		(A) <u>Disrupt pulmonary tumor</u> <u>or severe sepsis</u>			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>9-12-66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>THROMBOCYTOSIS, R. THROM</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>8/27</u> <u>19 66</u> to <u>9/23</u> <u>19 66</u> , that (we) last saw the deceased alive on <u>9/23/66</u> <u>19</u> and that in (my) <u>apinlan</u> death occurred on the date and hour and from the causes stated above. (I) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Merwin L. Trail</u>				23B. DATE SIGNED <u>9/23/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>MERWIN L. TRAIL</u>				23D. ADDRESS <u>CHURCH HOME &amp; HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/27/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Meadowridge Memorial Park</u>	
24D. LOCATION <u>Howard Co., Maryland</u>		24E. ADDRESS <u>Bruzdinski Funeral Home 1407 Eastern Ave.</u>		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Bruzdinski Funeral Home</u>	



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09725				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09725	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Adler, Elmer</i>			
2. DATE AND HOUR OF DEATH <i>25 Sept 1966 6:10 A.M.</i>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>SOUTH BALTIMORE GENERAL HOSPITAL 1243 South Light St BALTIMORE, MARYLAND</i>				A. STATE <i>MD.</i> B. COUNTY <i>BALTIMORE CITY</i>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 24-04</i>				D. STREET ADDRESS (If rural, give location) <i>429 E. FORT AVENUE</i>			
5. SEX <i>Male</i>	6. RACE <i>Caucasian</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>1-1-93</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur (Retired)</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem Steel</i>		11. BIRTHPLACE (State or foreign country) <i>MD?</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Edward Adler</i>				14. MOTHER'S MAIDEN NAME <i>Virginia Rudolph</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215057207</i>		17. INFORMANT <i>Wife</i>		ADDRESS	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) <i>Upper Gastrointestinal Hemorrhage</i>		<i>3 days</i>	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>22 Sept 66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Upper GI Bleeding</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>22 Sept 19 66</i> to <i>25 Sept 19 66</i> , that (I) (we) last saw the deceased alive on <i>25 Sept 19 66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death.							
23A. SIGNATURE <i>William J. Smith</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>25 Sept 1966</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/28/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill Cemetery</i>		24D. LOCATION (City, town or county) (State) <i>Baltimore Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 26 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>McCullough</i>		ADDRESS <i>130 E. Fort Ave. Bal. 30.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 09726					CERTIFICATE OF DEATH					Registered No. 66 09726				
1. NAME OF DECEASED (Type or Print) <b>LUTHER H.G. SMITH</b>					2. DATE AND HOUR OF DEATH <b>9-27-66 6:35 A.M.</b>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>Melchor Nursing Home</b> <b>2327 N CHARLES ST</b>					(If not in hospital or institution, give street address or location)					A. STATE <b>MARYLAND</b>				
										B. COUNTY				
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 1-05</b>				
										D. STREET ADDRESS (If rural, give location) <b>2203 E LOMBARD ST</b>				
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>AUG 31 1886</b>		9. AGE (In years lost birthday) <b>80</b>		If Under 1 Yr. Months		If Under 24 Hrs. Days		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SUB FOREMAN</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>CROWN CORK &amp; SEAL CO</b>					11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					13. FATHER'S NAME <b>DANIEL SMITH</b>					14. MOTHER'S MAIDEN NAME <b>SUSAN LANE</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>213-01-0351</b>					17. INFORMANT <b>MATILDA SMITH 2203 E LOMBARD ST</b>				
18. <b>163X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>C.A. of the lung &amp; generalized Metastases</b>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <b>0</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <b>No</b>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>9-24-1966</b> to <b>9-27-1966</b> , that (I) (we) last saw the deceased alive on <b>9-27-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <b>Cesar Valle Cervero</b> M.D.										23B. DATE SIGNED <b>9-27-66</b>				
23C. PHYSICIAN'S NAME (Type) <b>CESAR VALLE CAVERO</b> M.D.										23D. ADDRESS <b>8629 Liberty Rd</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>					24B. DATE <b>SEPT 30 66</b>					24C. NAME of CEMETERY or CREMATORY <b>GARDENS OF FAITH CEM</b>				
24D. LOCATION (City, town, or county) (State) <b>TRUMPS MILL RD MD</b>					25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>					25B. NAME OF REGISTRAR <b>John E. Taylor, M.D.</b>				
25C. FUNERAL DIRECTOR <b>DIPPEL BROS INC</b>					25D. ADDRESS <b>1800 E LOMBARD ST</b>									

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BALTIMORE CITY HEALTH DEPARTMENT

66 09727

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Anna Koletschke

2. DATE AND HOUR PRONOUNCED DEAD

9/19/66 11:25 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

215 N. Kenwood Ave.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Aug 18, 90

9. AGE (In years  
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEKEEPER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Theo. W. Koletschke

14. MOTHER'S MAIDEN NAME

Augusta Ehmanna

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

SISTER

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREWerner U. Spitz, M.D.  
NAME (Type)CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/19/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Sept. 27, 66

23C. NAME of CEMETERY or CREMATORY

Immanuel Cem.

23D. LOCATION

(City, town or county)

BALTO MD

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 26 1966

WALLER PHOTO

PAID CONVEYANCE

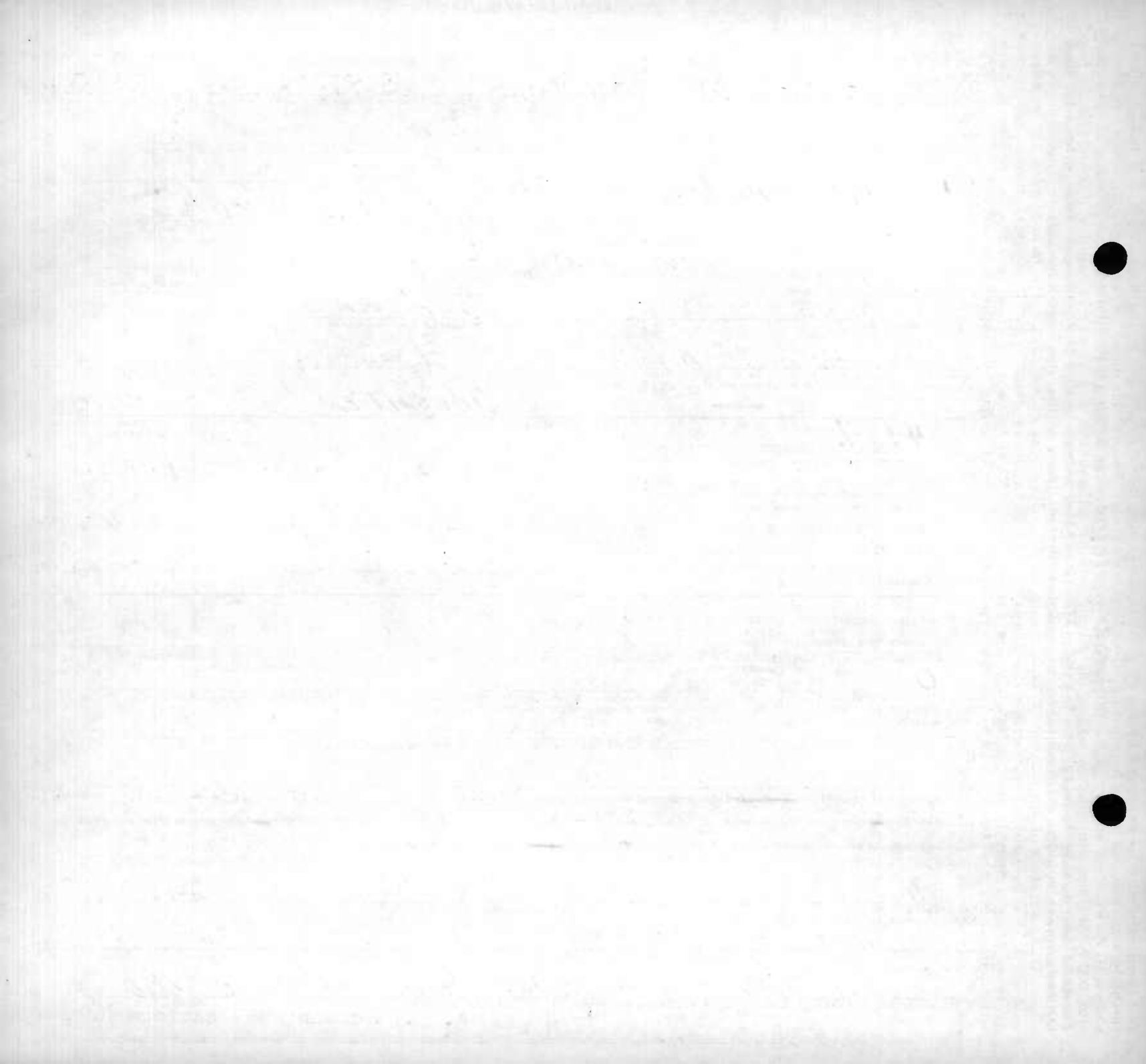
1911



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09728	
BIRTH NO. 66 09728		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ANNA M. HANSEN</b>		2. DATE AND HOUR OF DEATH <b>SEPT. 22, 1966 2:05 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>1723 Rambelwood Rd</b>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO 27-38</b>	
		D. STREET ADDRESS (If rural, give location) <b>1723 Rambelwood Rd</b>			
5. SEX <b>F</b>	6. RACE <b>W.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>Dec. 1</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>B Germany</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Carl Albert Behnke</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>DAUGHTER</b>	
				ADDRESS <b>SAME</b>	
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <b>Pulmonary Edema</b> DUE TO (B) <b>Cardio-Vascular Hypertensive Disease - 9 years</b> DUE TO (C) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>9 years</b>	
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>July 1957</b> to <b>Sept. 22, 1966</b> , that (I) ( <del>lost</del> ) lost saw the deceased alive on <b>Sept. 21, 1966</b> and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>lost</del> ) (did) ( <del>lost</del> ) view the body after death.					
23A. SIGNATURE <b>Michael J. Dausch</b>				23B. DATE SIGNED <b>Sept. 22, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>MICHAEL J. DAUSCH</b>				23D. ADDRESS <b>4636 BELAIR ROAD, BALTIMORE MD. 21206</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/24/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>IMMANUEL Cem.</b>	
24D. LOCATION <b>BALTO MD</b>		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		24H. NAME OF REGISTRAR <b>P. A. Heemann</b>		24I. FUNERAL DIRECTOR <b>P. A. Heemann 6067 Harford Road</b>	

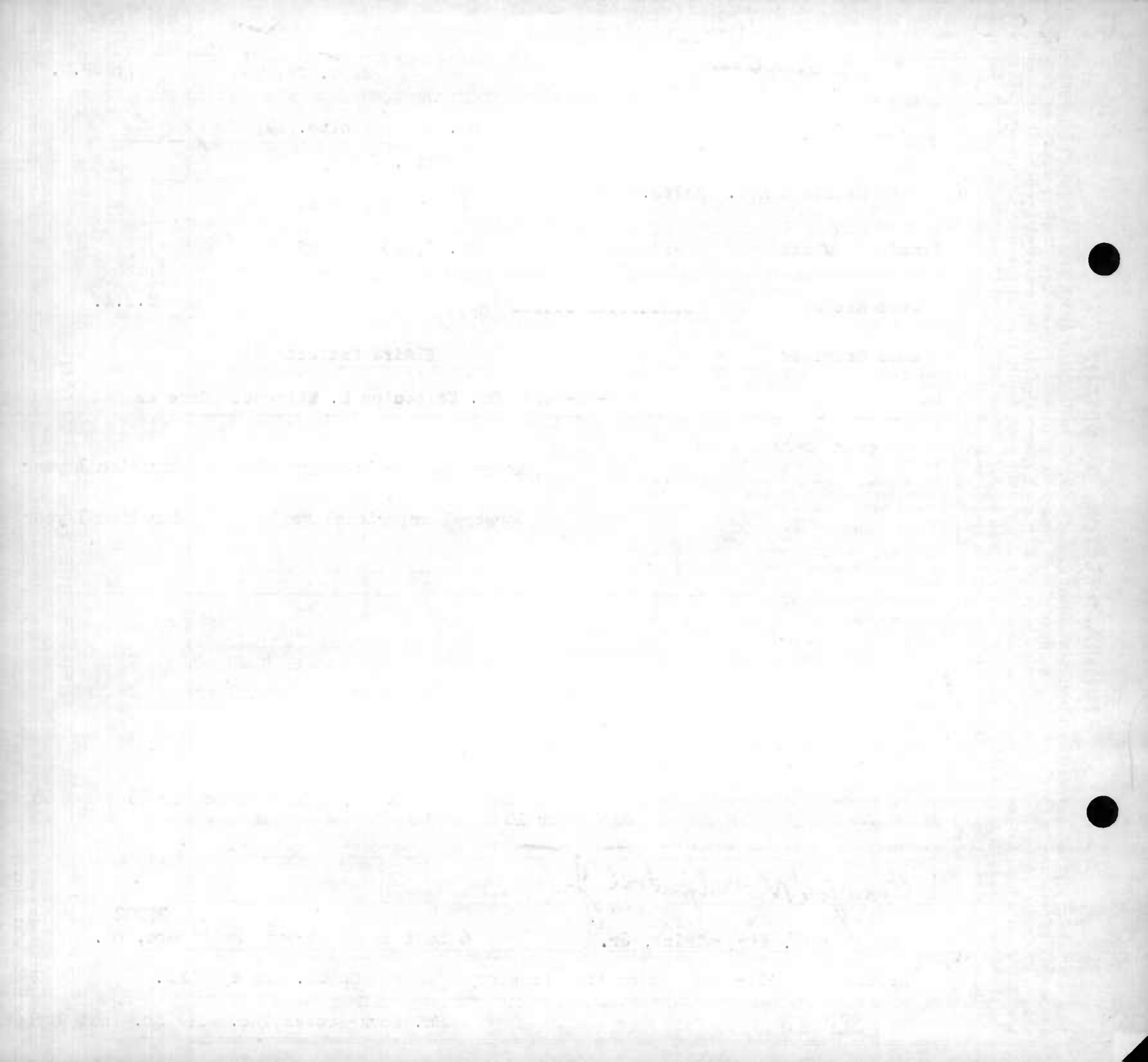




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

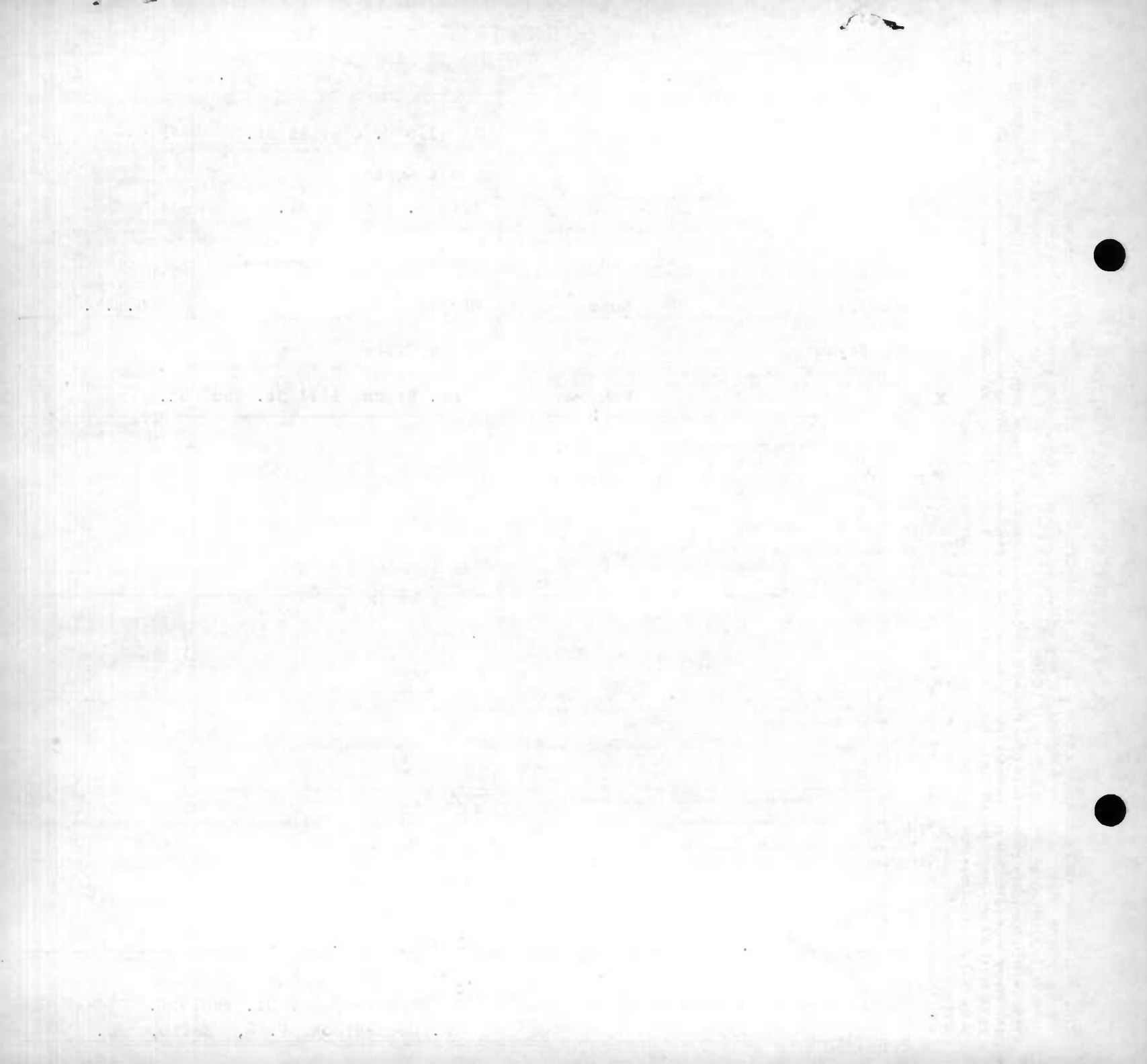
BIRTH NO. 66 09729		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09729	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		M.	
LURA VIOLA DAWSON		Sept. 26, 1966		7:30P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY Balto.	
1449 Medfield Ave. Balto.		C. CITY OR TOWN Balto. County		53-00	
		D. STREET ADDRESS (If rural, give location)			
		22 Bachanan Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Nov. 6, 1880	9. AGE (In years lost birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Gardiner		14. MOTHER'S MAIDEN NAME Elmira Catlett	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-30-4475		17. INFORMANT Dr. Valcoulon L. Ellicott Same as #4	
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Arteriosclerotic heart disease duration 1 year DUE TO (B) Cerebral arteriosclerosis duration 1 year DUE TO (C) -----		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 16 19 66 to September 26 19 66, that (I) (we) last saw the deceased alive on September 16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Crawford N. Kirkpatrick, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Crawford N. Kirkpatrick, Jr.		6 East Eager Street Baltimore, Md.		21202	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	9-29-1966	Cedar Hill Cemetery	Balto. County Md.		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 26 1966		Robert E. Farley		Wm. Cook-Brooks, Inc. 1217 St. Paul Street	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

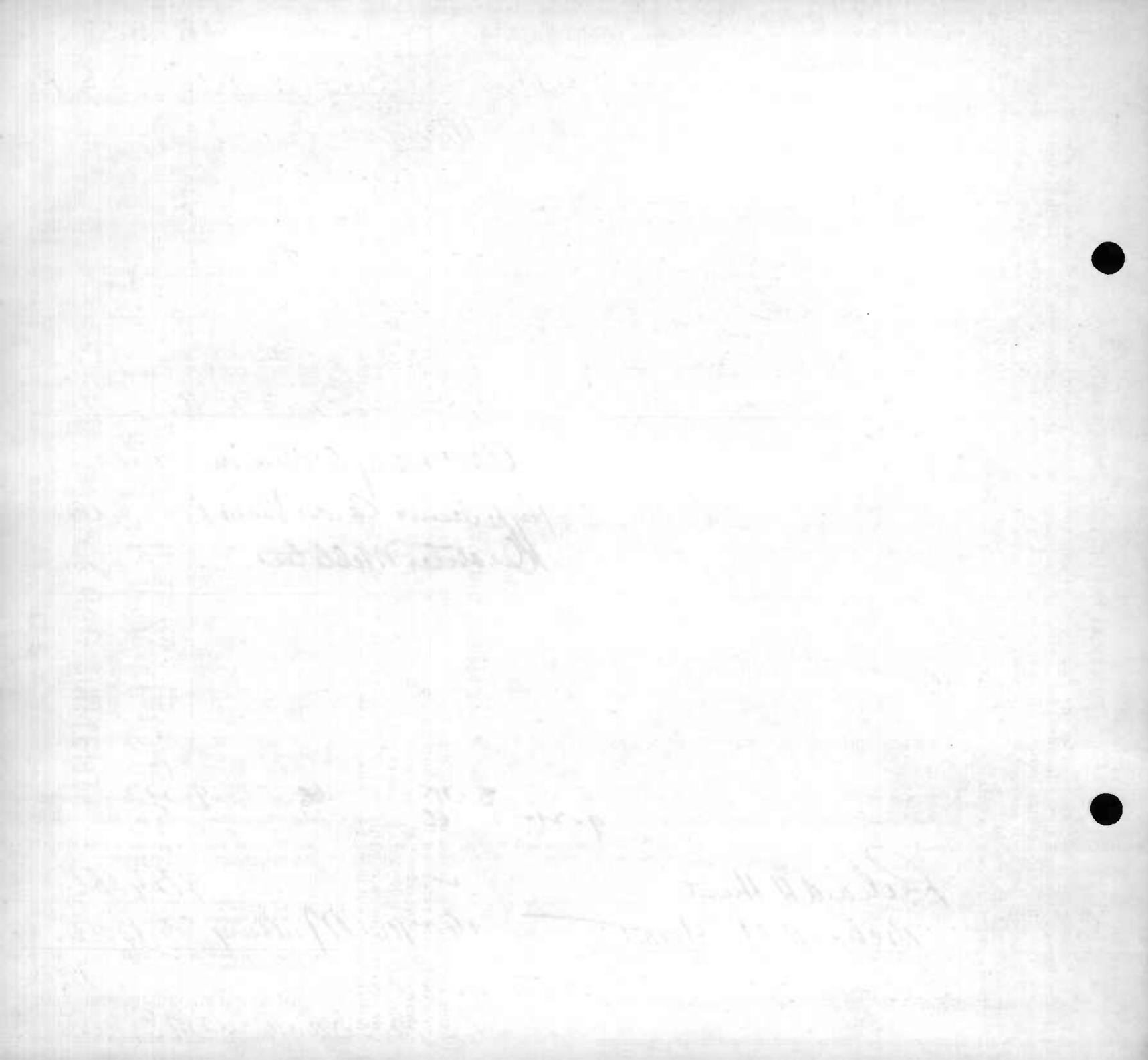
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09730</u>	
BIRTH NO. <u>66 09730</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Nina Wuster</u>		2. DATE AND HOUR OF DEATH <u>Sept 23, 1966</u>   <u>12: 45P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u> (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>1216 N. Charles St.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas Bryan</u>			14. MOTHER'S MAIDEN NAME <u>Anne Price</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/> No		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT ADDRESS <u>Mr. Bryan 1721 St. Paul St.</u>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Fulminant Tuberculosis</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Old Tuberculosis</u> DUE TO			
		(C) <u>Cachexia malnutrition, Dehydration, Anemia</u>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>None</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>None</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 21</u> 19 <u>66</u> to <u>Sept 22</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 23</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John G. Green</u> M.D.				23B. DATE SIGNED <u>9/23/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>John G. Green</u> M.D.				23D. ADDRESS <u>Mercy Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>	24B. DATE <u>9/27/66</u>	24C. NAME of CEMETERY or CREMATORY <u>Greenmount Crematory</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR 1217 St. Paul St. ADDRESS <u>Wm. Cook-Brooks F. H., Balto., Md.</u>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO.	
66 09731		<b>CERTIFICATE OF DEATH</b>		66 09731	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lula Mc Gowan		Sept 21-1966 845 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
		A. STATE Maryland		B. COUNTY 10-07	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
3028 Presstman St		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		3028 Presstman St			
5. SEX F.	6. RACE Col	7. MARRIED, NEVER MARRIED WIDOWED / DIVORCED (specify) Widow	8. DATE OF BIRTH 1-1-1895	9. AGE (In years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Jones			14. MOTHER'S MAIDEN NAME Mariah Jones		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT Norman Smith 12 Winter Lane	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CORONARY I			CAUSE OF DEATH (A) DUE TO Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 2 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO Hypertensive Cardiovascular Dis		Unknown
			(C) Diabetes Mellitus		Unknown
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-15-1966 to 9-21-1966, that (I) (we) last saw the deceased alive on 9-21-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard H. Hunt				23B. DATE SIGNED 9/24/66	
23C. PHYSICIAN'S NAME (Type) Richard H. Hunt				23D. ADDRESS 1607 W. Mulberry St, Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9/26/66		24C. NAME OF CEMETERY OR CREMATORY St. Ignace Memorial Park	
24D. LOCATION (City, town, or county) (State) Md		25A. DATE REC'D BY HEALTH DEPT. SEP 26 1966		25B. NAME OF REGISTRAR Rayner Sanders	
		25C. FUNERAL DIRECTOR 217 E. Preston St		ADDRESS	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09732	
BIRTH NO. 325 66 09732				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MAJOR MATTISON		2. DATE AND HOUR OF DEATH 9/23/66 5:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 12-04 D. STREET ADDRESS (If rural, give location) 302 WORSLEY ST. #21218			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9-8-05	9. AGE (In years lost birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
13. FATHER'S NAME WILLIAM		14. MOTHER'S MAIDEN NAME ROSE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT BALTIMORE CITY HOSPITALS RECORDS: 4940 EASTERN AVE. BALTO., MD. #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 180X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Sub-arachnoid hemorrhage (B) Carcinomatous meningitis (C) Renal cell carcinoma		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 3 months 7 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Essential hypertension				16 yrs.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/22 1966 to 9/23 1966, that (I) (we) last saw the deceased alive on 9/23 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Craig A. Johanson				23B. DATE SIGNED 9/23/66	
23C. PHYSICIAN'S NAME (Type) CRAIG A. JOHANSON				23D. ADDRESS 4940 EASTERN AVE. BALTO., MD. #21224 BALTIMORE CITY HOSPITALS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/27/66		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Em. A. C. Co	
25A. DATE RECEIVED BY HEALTH DEPT. 10/1/66		25B. NAME OF REGISTRAR John E. Talley		25C. FUNERAL DIRECTOR Rayner Sanders 217 E. Preston St	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09733</u>	
BIRTH NO. <u>66 09733</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>John C. Angier Jr.</u>			2. DATE AND HOUR OF DEATH <u>Sept. 26, 1966</u> <u>5 P.M.</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospt. (D.O.A.)</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>9-01</u> D. STREET ADDRESS (If rural, give location) <u>900 Argonne Drive</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>10-27-1897</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lithographer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Federal Tin</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John C. Angier</u>			14. MOTHER'S MAIDEN NAME <u>Lida Duke</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW 1</u>		16. SOCIAL SECURITY NO. <u>166-07-0753</u>	17. INFORMANT <u>Catherine C. Angier</u>		ADDRESS <u>Above</u>
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Occlusion</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>31 March 1965</u> to <u>26 Sept 1966</u> , that (I) <u>we</u> last saw the deceased alive on <u>2 Sept 1966</u> and that in (my) <u>your</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Anderson M. Renick Jr.</u>			23B. DATE SIGNED <u>27 Sept 66</u>		
23C. PHYSICIAN'S NAME (Type) <u>Anderson M. Renick Jr. M.D.</u>			23D. ADDRESS <u>1010 St. Paul St., Balto., Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9-29-66</u>	24C. NAME of CEMETERY or CREMATORY <u>Parkwood</u>	24D. LOCATION <u>Parkville</u>	(City, town, or county) (State) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1966</u>		25B. NAME OF REGISTRAR <u>R. O. B. E. F. A. R. A. N. A.</u>	25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>		
		ADDRESS <u>4905 York Rd.</u>			

Journal of the

21 May 1952

25th

Chickadee

X

27th

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09734		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09734	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 9/26/66 655 P M.	
1. NAME OF DECEASED (Type or Print) HELEN CRABBE TAYLOE		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. - Baltimore B. COUNTY 11-04	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital		5. SEX F 6. RACE Caucasian 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 8-6-81 9. AGE (In years last birthday) 85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK (Retired) OFFICE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Walter Randolph CRABBE		14. MOTHER'S MAIDEN NAME Elizabeth Talliaferro Zimmerman		12. CITIZEN OF WHAT COUNTRY? America (USA)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 237-78-3381-A		17. INFORMANT ADDRESS MISS BETSY TAYLOE (SAME)	
18. 435.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) STOKES-ADAMS SYNDROME DUE TO (B) ARTERIOSCLEROTIC VASCULAR DISEASE DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CEREBRAL HEMORRHAGE		19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 25 SEPT 1966 to 26 SEPT 1966, that (I) (we) last saw the deceased alive on 26 SEPT 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sidney E. Kirkley		23B. DATE SIGNED 26 SEPT 66		23C. PHYSICIAN'S NAME (Type) SIDNEY E. KIRKLEY	
24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial		24B. DATE 9/29/1966		24C. NAME OF CEMETERY or CREMATORY Yeocomico Church	
24D. LOCATION (City, town, or county) Westmoreland, Virginia		24E. NAME OF REGISTRAR H.W. Jenkins & Sons Co.		24F. FUNERAL DIRECTOR ADDRESS 4905 York Rd. Balto. 12, Md.	

1957 06/06 1957

Union Memorial Hospital

F. Carson answered

Chief (Retired)

Walter Randolph 0988

1957 06/06

Mr. - Baltimore

Baltimore

1315 Bolton Street

8-6-81 82

Baltimore, Md.

Elizabeth Talle Zimmerman

1957 06/06

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 09735		CERTIFICATE OF DEATH		Registered No. 66 09735		
1. NAME OF DECEASED (Type or Print) <b>Benjamin Robinson Haslup</b>				2. DATE AND HOUR OF DEATH <b>9-26-66 12:05 P M.</b>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #14 27-03</b> D. STREET ADDRESS (If rural, give location) <b>3313 Ailsa Avenue</b>						
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>3-31-86</b>	9. AGE (In years lost birthday) <b>80</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Supt.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Leroy Fennell Haslup</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Jane Washington</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Marie A. Haslup</b>		ADDRESS <b>(Same)</b>			
18. <b>153.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ASHD</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Ca of Sigmoid Colon &amp; multiple Metastases.</b> DUE TO (B) <b>ASHD</b> DUE TO (C) <b>CHF 2° to ASHD.</b>				INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <b>8/24/66</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca of Sigmoid Colon</b>			20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>8/15</b> 19 <b>66</b> to <b>9/26</b> 19 <b>66</b> , that <del>it</del> (we) last saw the deceased alive on <b>9/26</b> 19 <b>66</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(We)</del> (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>David S. Schwartz</b>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/22/66.</b>		
23C. PHYSICIAN'S NAME (Type) <b>David S. Schwartz</b>						23D. ADDRESS <b>Union Memorial Hospital</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/30/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>			25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>			ADDRESS <b>21214</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09736</u>	
BIRTH NO. <u>66 09736</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ECKHARDT, FREDERICK H.</u>		2. DATE AND HOUR OF DEATH <u>9/26/66</u> <u>11 45</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hosp.</u>		A. STATE <u>MARYLAND</u> B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE #13 8-61</u>			
		D. STREET ADDRESS (If rural, give location) <u>2710 ERDMAN AVENUE</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>06-12-01</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Tobacco Co.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>HENRY ECKHARDT</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET PAUSCH</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>401-09-9784</u>		17. INFORMANT ADDRESS <u>Mrs. Madeline V. Eckhardt (Same)</u>	
18. <u>493X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>SEPTIC AEMIA</u>		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <u>MYOCARDIAL INFARCTION</u>			
		(C) DUE TO <u>PNEUMONIA</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/18/66</u> to <u>9/26/66</u> that (I) (we) last saw the deceased alive on <u>9/26/66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>DR. ZOLTON ZARDAY</u>				23B. DATE SIGNED <u>9/26/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>ZOLTON ZARDAY</u>				23D. ADDRESS <u>Union Memorial Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/26/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 09737</span>	
BIRTH NO. <span style="float: right;">66 09737</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>VON KENNEN, AMELIA DORA</b>		2. DATE AND HOUR OF DEATH <b>SEPT. 26, 1966 2:05 PM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSPITAL</b>		A. STATE <b>MARYLAND</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
<b>33RD AND CALVERT ST., BALTIMORE, MD 21218</b>		D. STREET ADDRESS (If rural, give location) <b>5601 HILLTOP AVENUE</b>			
5. SEX <b>F</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>03-02-85</b>	9. AGE (In years lost birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		13. FATHER'S NAME <b>FREDERICK Wm. LALLMAN</b>		14. MOTHER'S MAIDEN NAME <b>DORA ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-07-6174</b>		17. INFORMANT <b>Mr. Edward Blunt 7083 Belcare Rd.</b>	
18. <b>I</b> <b>170X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAR. OF BREAST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>CAR. OF BREAST</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>AUG 2, 1966</b> to <b>SEPT. 26, 1966</b> , that (I) (we) last saw the deceased alive on <b>SEPT 26, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>PMCI</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>PMCI</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. JOSEPH C. HOOPER</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL 108 EAST THIRTY-THIRD ST., 18</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/29/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Cem.</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. STATE <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>	
25D. ADDRESS <b>21214</b>					

V. K. Kishore, Ahmedabad

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09738	
BIRTH NO. 66 09738		<b>CERTIFICATE OF DEATH</b>		9/26/66 12 <sup>35</sup> A.M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) REUWER, MRS. EMMA T.		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND MARYLAND GENERAL HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 827 LINDEN AVE BALTIMORE, Md.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZIP: 21234 D. STREET ADDRESS (If rural, give location) 3027 CHELSEY AVE 5300			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 8/4/1880	9. AGE (In years lost birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE SIPLER		14. MOTHER'S MAIDEN NAME KATHRYN JORDAN		17. INFORMANT ADDRESS KATHRYN HALL 3314 REUKERT AVE 21214	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-52-0254		17. INFORMANT ADDRESS KATHRYN HALL 3314 REUKERT AVE 21214	
18. 400.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Enlarged atherosclerosis (B) DUE TO Chronic renal disease (C) Rheumatic heart disease		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/25/66 to 9/26/66, that (I) (we) last saw the deceased alive on 9/26/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 9/26/66	
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS [Signature]	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/29/66		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 26 1966		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214	

REIMER, MRS. EMMA T.

MARYLAND GENERAL HOSPITAL

MD.

827 LINDEN AVE  
BALTIMORE, MD

3021 CHESTNUT AVE  
BALTIMORE

FEMME WHITE WIDOW

8/4/1910 86

MONIE

GEORGE ZIELEK

KATHARIN JORDAN

NO

218-2-0024

KATHARIN HALL 331 REIMER

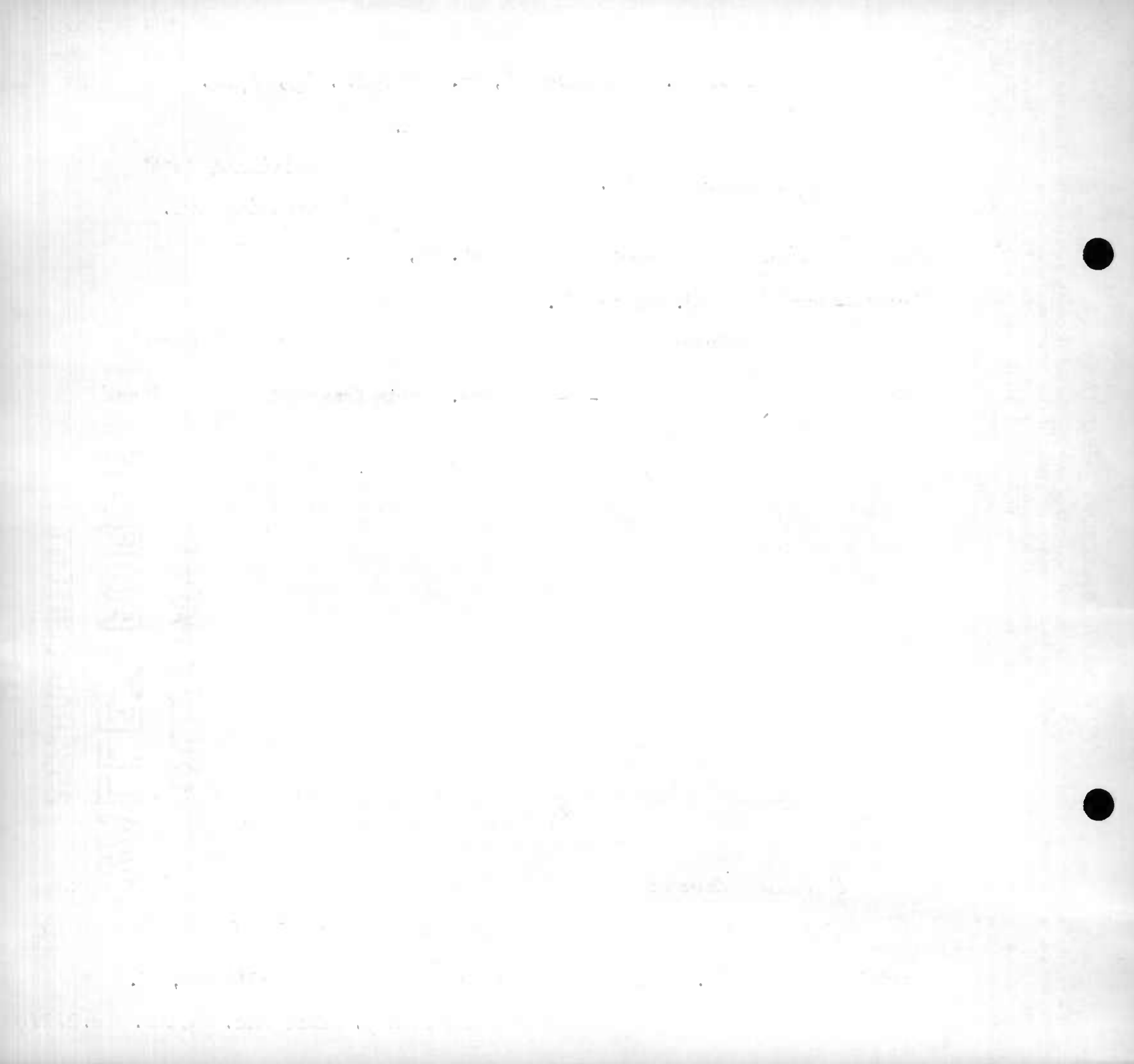
Handwritten notes:  
George and Emma  
Katharine Jordan

Handwritten signature: *Frank H. ...*  
Date: 8/5/10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09739	
BIRTH NO. 66 09739		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Walter S. Krasowski, Sr.		2. DATE AND HOUR OF DEATH Sept. 25, 1966. 8 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3532 Woodring Ave.		A. STATE Md.		B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #34 27-05			
		D. STREET ADDRESS (If rural, give location) 3532 Woodring Ave.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 10, 1909.	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman--Guard		10B. KIND OF BUSINESS OR INDUSTRY Md. Drydock Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Anna (Unknown)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-24-1908		17. INFORMANT Mrs. Sophie Krasowski	
				ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Myocardial Infarction (B) Hypertension Arteriosclerotic Heart (C)		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr 5 years	
19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 31 1966 to Sept. 25 1966, that (I) (we) last saw the deceased alive on Sept. 24 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Adam G. Swiss		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Sept. 26, 1966	
23C. PHYSICIAN'S NAME (Type) ADAM G. SWISS		23D. ADDRESS 6232 Delain Rd., Balto. Md. 21206			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/28/66.		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
				24D. LOCATION (City, town, or county) Baltimore, Md. (State)	
25A. DATE REC'D BY HEALTH DEPT. SEP 26 1966		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214	
				ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09740	
BIRTH NO. 66 09740				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>EDWARD M. KELLY</b>			2. DATE AND HOUR OF DEATH <b>9-26-66</b> <b>3</b> <b>A</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>MD. GENERAL HOSP.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>MD. GENERAL HOSP.</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b>		
(If not in hospital or institution, give street address or location)			D. STREET ADDRESS (If rural, give location) <b>5153 CEDGATE RD.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10-08-98</b>	9. AGE (in years last birthday) <b>67</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POLICEMAN (Retired)</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>EDWARD Wm. KELLY</b>			14. MOTHER'S MAIDEN NAME <b>EMMA WILSON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>217-30-3014</b>		17. INFORMANT <b>MRS. CATHERINE KELLY</b>
					ADDRESS <b>SAME</b>
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic heart disease</b>			CAUSE OF DEATH (A) DUE TO <b>Arteriosclerotic heart disease</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO <b>Arteriosclerotic Cardiovascular disease</b>		
			(C) <b>Pulmonary emphysema</b>		
			<b>Tracheobronchitis</b>		
			<b>Pulmonary emboli.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-18</b> <b>1966</b> to <b>9-26</b> <b>1966</b> , that (I) (we) last saw the deceased alive on <b>9-26</b> <b>1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Donald E. Fink</b>				23B. DATE SIGNED <b>Sept. 26, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>MD. General Hosp.</b>				23D. ADDRESS <b>MD. General Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/29/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>	



Robert Wilson

Nov 11/14



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09741	
BIRTH NO. 66 09741		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Lillian May Vogel</b>		2. DATE AND HOUR OF DEATH <b>9/23/1966 6:45 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Hopkins Apartments 3100 St. Paul St.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3100 St. Paul Street 21218</b>	
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 24, 1888</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <b>77</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>August Kimpel</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Shoemack</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Margaret Perin</b>		ADDRESS <b>1031 N. Calvert St.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Heart Disease</b> <b>Arteriosclerosis, generalized</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>NONE</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>9/23/1966</b> , that (I) (we) lost saw the deceased alive on <b>July 30 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Robert T. Parker M.D.</b>		23B. DATE SIGNED <b>9/23/1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT T. PARKER</b>		23D. ADDRESS <b>SOUTH BALTO GEN. HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9/26/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>William J. Trickett</b>		ADDRESS <b>1118 E. ...</b>	

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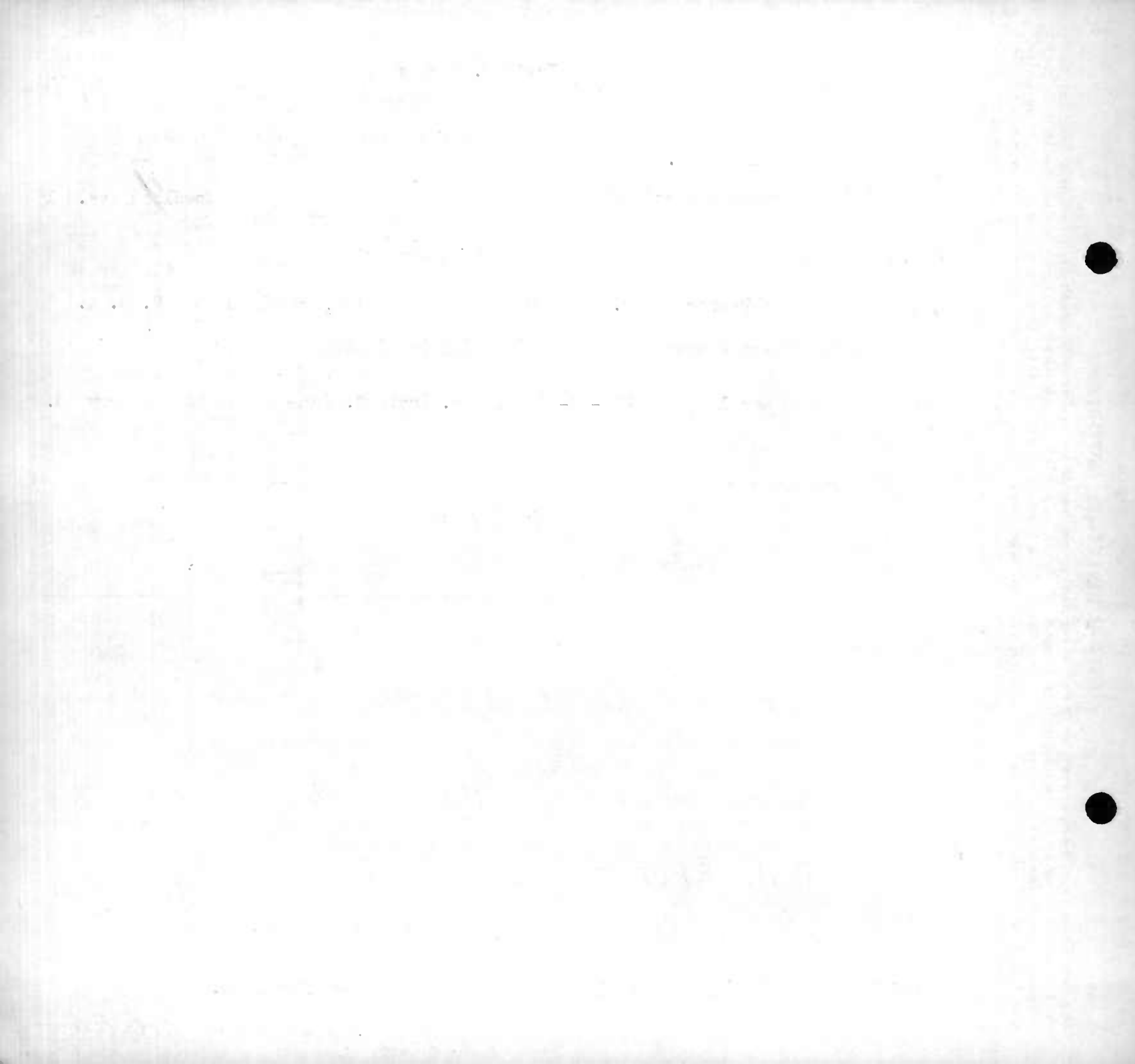
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09742	
66 09742					
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>HUGHES, IRVIN</b>		2. NAME OF DECEASED (Type or Print) <b>Trvin D. Hughes</b>		3. DATE AND HOUR OF DEATH <b>9/23/66 4:09 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>WOODLAND AVE.</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		D. STREET ADDRESS (If rural, give location) <b>3026 WOODLAWN AVE. 15</b>			
5. SEX <b>MALE</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>1896 10/26/96</b>	9. AGE (In years last birthday) <b>70 69</b>	10. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Bookkeeper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Fed. Reserve Bank</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Clarence Hubert Hughes</b>			14. MOTHER'S MAIDEN NAME <b>Jennie Minnick</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War 1</b>		16. SOCIAL SECURITY NO. <b>217-03-7928 A</b>		17. INFORMANT ADDRESS <b>Mr. Irvin C. Hughes 2524 Londonderry Rd.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>420.15260X</b>		CAUSE OF DEATH (A) <b>MI</b> DUE TO (B) <b>ASHD</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b>	
19. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>DIABETES MEL.</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from <b>9/23</b> 19 <b>66</b> to <b>9/23/66</b> 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>9/23</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>D.A. SPOTT</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/23/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>David A. Spott</b>		23D. ADDRESS <b>SINAI HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/27/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Woodlawn, Md.</b>		24E. STATE <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wm J. Fickert</b>	
25D. ADDRESS <b>1111 N. ...</b>		25E. ADDRESS <b>1111 N. ...</b>			



K-600

66 09743

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09743

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

DONALD KERR

2. DATE AND HOUR PRONOUNCED DEAD

September 22, 1966 7:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Jessup

D. STREET ADDRESS (If rural, give location)

Greenway Motel Route #2, Box 600

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Jan 7, 1930

9. AGE (In years  
lost birthday)

38 36

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Butler Aviation

11. BIRTHPLACE (State or foreign country)

Bogalusa Louisiana

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Roban Lackworth

14. MOTHER'S MAIDEN NAME

Rosemond Eve Houck

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Bultman Mortuary New Orleans La.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐ September 23, 196623A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

23B. DATE

9/25/66

23C. NAME of CEMETERY or CREMATORY

Hope Mausoleum

23D. LOCATION

(City, town, or county)

New Orleans, Louisiana

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 26 1966

# VALLEY FORCE

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09744		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 09744	
1. NAME OF DECEASED (Type or Print) <u>Ellie M. Burke</u>			2. DATE AND HOUR OF DEATH <u>9-25-66</u> <u>1 8:10</u> <u>P.</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bolton Hill Nursing Home</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city, give rural and give township) <u>15-04</u> D. STREET ADDRESS (If rural, give location) <u>1744 West North Avenue</u> <u>17</u>		
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-14-1874</u>	9. AGE (In years last birthday) <u>92</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>
13. FATHER'S NAME <u>Jas W Black</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT ADDRESS <u>Mrs. Bertha Burke 2000 Gwynn Oak Ave.</u>		
18. CAUSE OF DEATH <u>450.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>generalized arteriosclerosis</u> (A) DUE TO  ANTECEDENT CAUSES (B) DUE TO  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) <u>osteoarthritis.</u>  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>several yrs.</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>no</u>	20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>?</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>no</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-24-66</u> 19 to <u>9-25-66</u> 19, that (I) (we) last saw the deceased alive on <u>9-21-66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. Ellsworth Cook</u>			23B. DATE SIGNED <u>9-25-66</u>		23C. PHYSICIAN'S NAME (Type) <u>E. ELLSWORTH COOK M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>9/29/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Mem. Pk. Cem.</u>
24D. LOCATION <u>Howard County, Md. land</u>			25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1966</u>		
25B. NAME OF REGISTRAR <u>Wm. J. Tichner</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Baltimore, Md. 21201</u>		



Wm. H. Miller



## CERTIFICATE OF DEATH

Registered No.

66 09745

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09745		Registered No. 66 09745	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 35 Sept 1966 8:00 P.M.	
1. NAME OF DECEASED (Type or Print) Robert. Irving Hassiter		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital 4940 Eastern Ave. Baltimore, Maryland #21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 715 Park Ave	
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9/13/03
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Desk Clerk		10B. PLACE OF BUSINESS OR INDUSTRY Alcazar Hotel	9. AGE (In years last birthday) 63
13. FATHER'S NAME Edward M. Hassiter		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		14. MOTHER'S MAIDEN NAME Lillian Gaskins	
16. SOCIAL SECURITY NO.		17. INFORMANT BCH: Records	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest Pulmonary Edema 3-4 hrs +		19. 162.1 I DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Antecedent Causes Bronchogenic Ca - Metastasis to Mediastinal Nodes	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (we) (this hospital) attended the deceased from 24 Aug 19 66 to 25 Sept 19 66, that (we) last saw the deceased alive on 25 Sept 19 66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dudley A. Raine Jr.		23B. DATE SIGNED 25 Sept 1966	
23C. PHYSICIAN'S NAME (Type) Dudley A. Raine Jr.		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/28/1966	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 26 1966		25B. NAME OF REGISTRAR R. E. Faldut	
25C. FUNERAL DIRECTOR Wm. J. Fairman & Sons		25D. ADDRESS Baltimore, Md. North Ave.	

Robert Morrison

Baltimore City Hospital

M. C. ...

Dr. Clark  
Edward W. Morrison

22 Sept 1902

William ...  
J12 Park Ave

2/13/03

William ...  
Virginia

Robert ...  
Baltimore

Branch ...

Dr. A. H. ...

22 Sept

at 10

at

22 Sept

at

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09746		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09746	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		LARRY B JACOBS		2. DATE AND HOUR OF DEATH Sept. 25 / 66 1:14 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Univ. Hosp.		A. STATE Md.		B. COUNTY BALTO. CITY	
		C. CITY OR TOWN BALTIMORE		4-61	
		D. STREET ADDRESS 8 N Howard St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8-24-87	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY THEATRE		11. BIRTHPLACE (State or foreign country) ENGLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME ABRAHAM JACOBS		14. MOTHER'S MAIDEN NAME JANE COHEN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT JOSEPH ANDREWS FUNERAL HOME NEW YORK N.Y.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ASCVD Myocardial Infarction		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 25 19 66 to Sept. 25 19 66, that (I) (we) last saw the deceased alive on Sept 25 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dean A. Giff		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-25-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 9/25/66		24C. NAME of CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State) NEW YORK N.Y.					
25A. DATE REC'D BY HEALTH DEPT. SEP 26 1966		25B. NAME OF REGISTRAR P. E. E. F. J. J.		25C. FUNERAL DIRECTOR Wm. Tichner & Son	
				ADDRESS Balt 17 Md.	

THOMAS JACOB

Sept 22

1914

BALTIMORE

Howard St.

18-81

John Hop

M

W

18-81

ASCHAD

Wendell Robert

No

Sept 22

Wm. H. H.

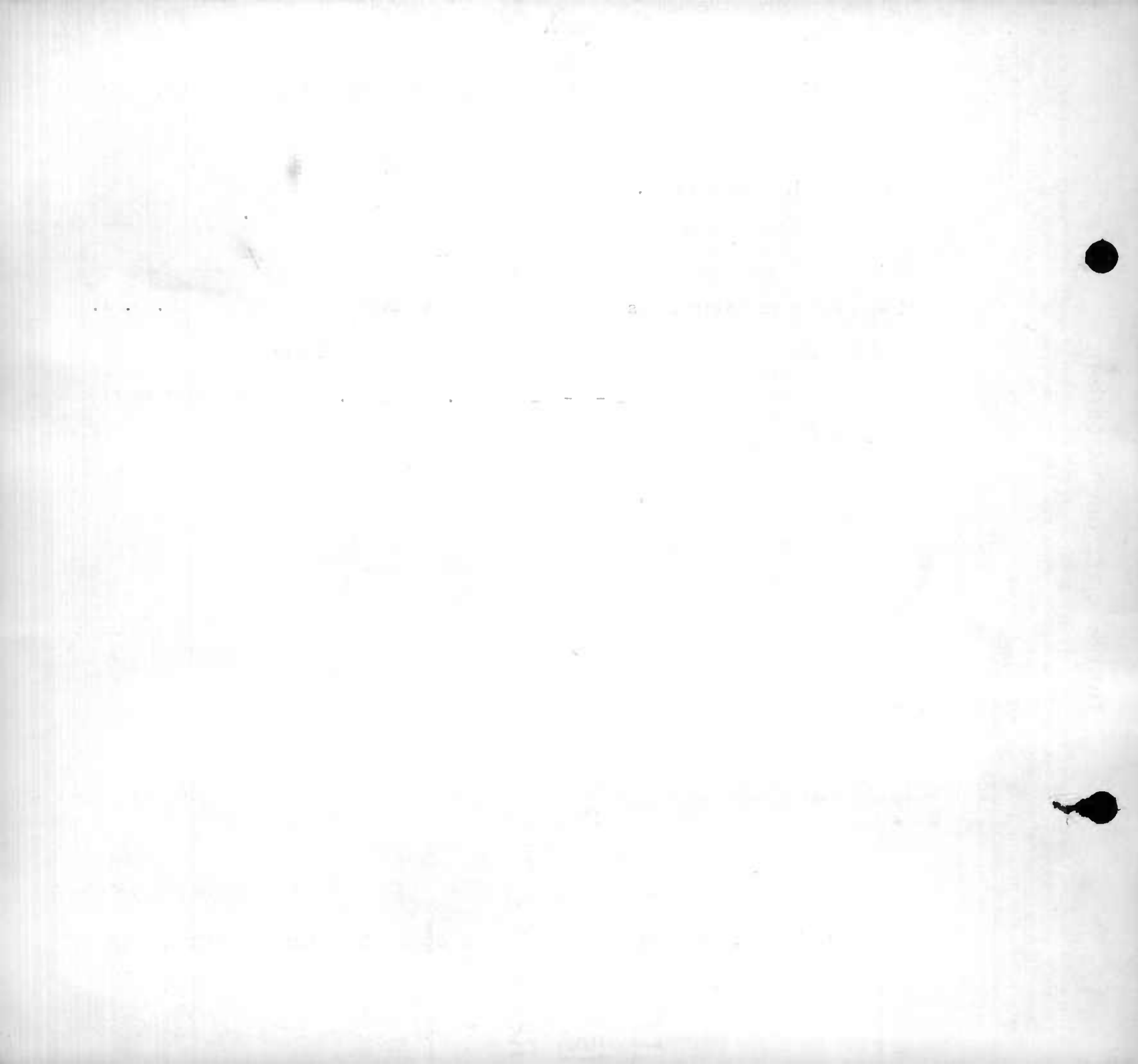
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18-81

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09747</u>	
BIRTH NO. <u>66 09747</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>1</u>			DATE AND HOUR OF DEATH <u>Sept 25, 1966 12 NOON M.</u>		
1. NAME OF DECEASED (Type or Print) <u>Robertson, John</u>			2. DATE AND HOUR OF DEATH		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL.</u>			A. STATE <u>MARYLAND</u>		
(If not in hospital or institution, give street address or location)			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE, 18</u>		
			D. STREET ADDRESS (If rural, give location) <u>3809 FENCHURCH RD. 12-01</u>		
5. SEX <u>MALE</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12-26-91</u>	9. AGE (In years, last birthday) <u>74</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President Duquesne Natural Gas</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>DUNCAN ROBERTSON</u>			14. MOTHER'S MAIDEN NAME <u>GRACE Fisher</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No None</u>		16. SOCIAL SECURITY NO. <u>212-03-5816</u>	17. INFORMANT ADDRESS <u>Mrs. Bessie B. Robertson same address</u>		
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Shock</u> (A) DUE TO <u>3 hours</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Blood loss</u> (B) DUE TO <u>30 hours</u>					
<u>Q.I. bleeding</u> (C) DUE TO <u>30 hours</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>pneumonia</u> <u>renal failure</u> <u>pulmonary emphysema</u>			<u>10 days</u> <u>4 days</u> <u>10 days</u> <u>10 years</u>		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <u>Sept 15 1966</u> to <u>Sept 25 1966</u> , that (we) last saw the deceased alive on <u>25 Sept 1966</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Daniel C. Hadlock</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>25 Sept 1966</u>
23C. PHYSICIAN'S NAME (Type) <u>Daniel C. Hadlock</u>			23D. ADDRESS <u>The Johns Hopkins Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9/27/66</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Cheslerfield Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Centerville, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1966</u>	25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>	25C. FUNERAL DIRECTOR <u>Wm. F. Tibner + Sons</u>			
			ADDRESS <u>Balto., Md.</u>		



1  
5500

66 09748

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09748

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

YENUNG KEI SHUN

2. DATE AND HOUR PRONOUNCED DEAD

September 12, 1966

8:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)S.S. Negs Victoria, Anchorage#3,  
Lower Harbor

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

China

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Hong Kong

D. STREET ADDRESS (If rural, give location)

03-02

5. SEX

Male

6. RACE

Yellow

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

-----?----

8. DATE OF BIRTH

about 1938

9. AGE (In years  
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

probably a Seaman.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

China

12. CITIZEN OF  
WHAT COUNTRY?

Prob. China.

13. FATHER'S NAME

could not ascertain

14. MOTHER'S MAIDEN NAME

could not ascertain

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

probably NO

16. SOCIAL  
SECURITY NO.

Probably NONE

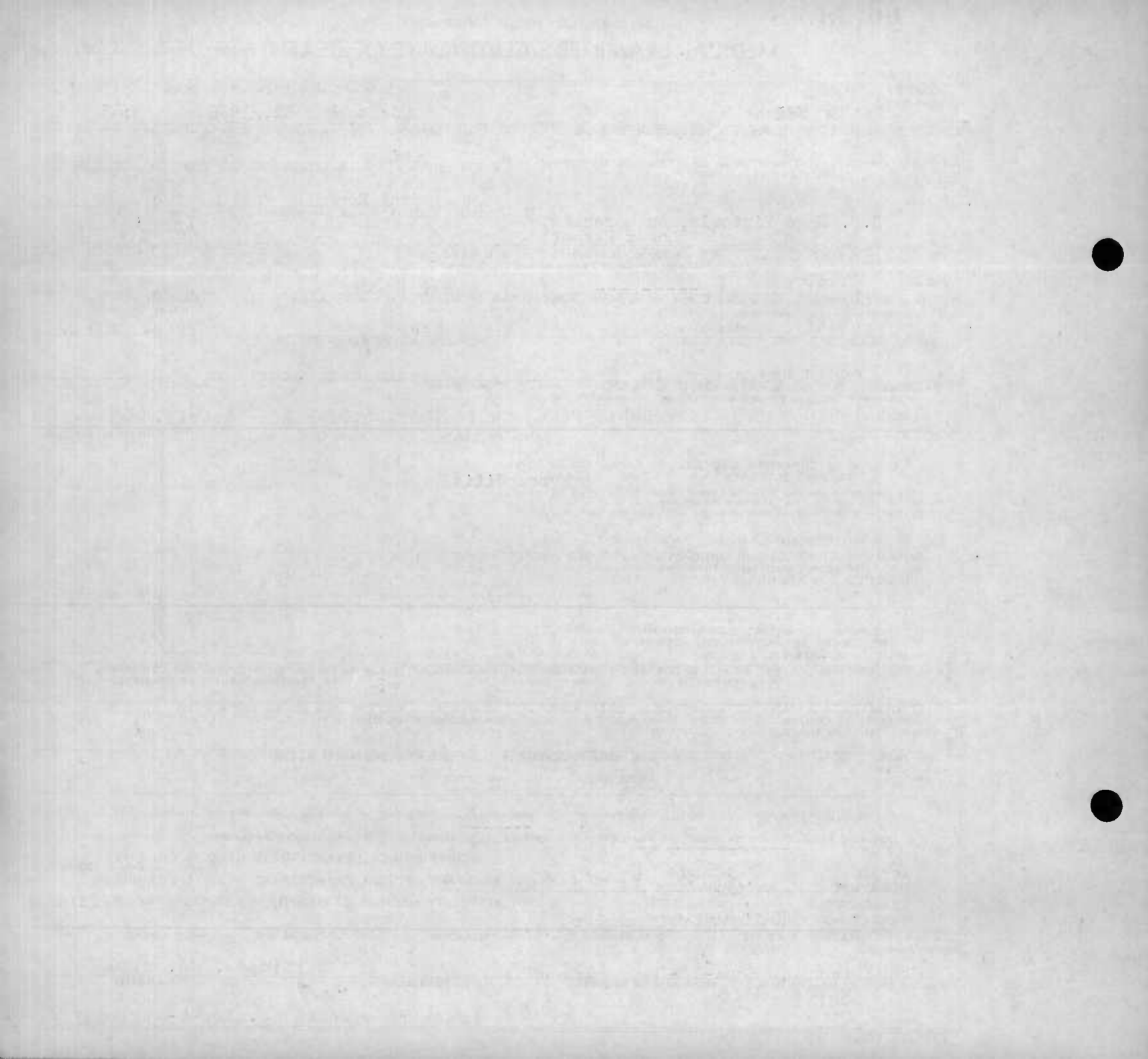
17. INFORMANT

ADDRESS

Niles, Barton, Gans and Markell. Balto-21201

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		
(A) Myocarditis DUE TO		
(B) DUE TO		
(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		DATE SIGNED
Rudiger Breitenecker		9/12/66
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY
Cremation	Sept-26-66	GreenMount
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR
SEP 26 1966	Robert E. Foley, M.D.	Stewart & Mowen Co. 108-W-North-Av 21201







1  
A-352

66 09749

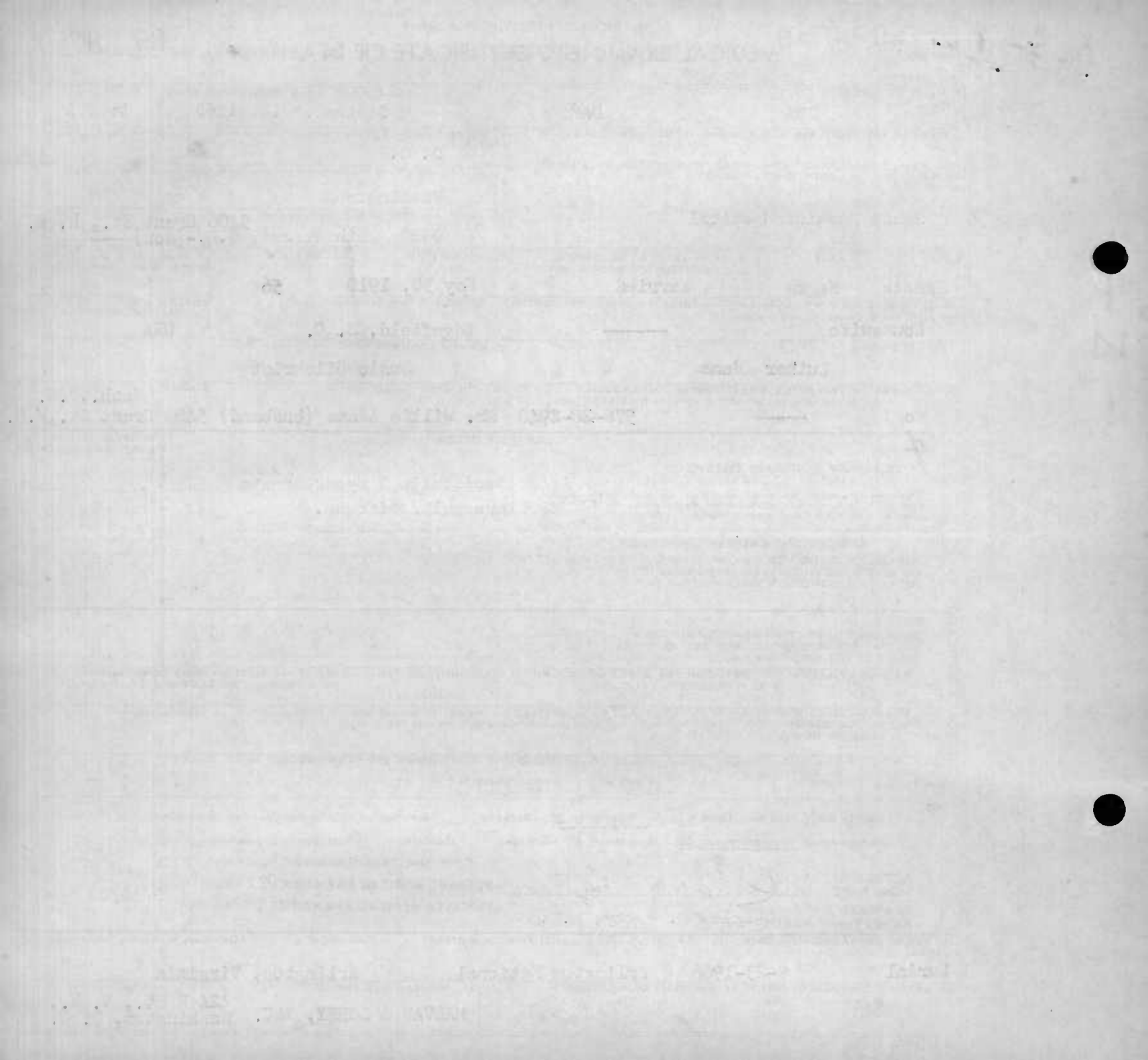
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09749

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>IDA ADAMS</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>September 18, 1966 1:20 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Johns Hopkins Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>D. C.</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Washington</b> D. STREET ADDRESS (If rural, give location) <b>5406 Grant St., N. E. 3433 25th Street, S.E.-(Son)</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 30, 1910</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11. BIRTHPLACE (State or foreign country) <b>Edgefield, S. C.</b>
13. FATHER'S NAME <b>Luther Adams</b>		14. MOTHER'S MAIDEN NAME <b>Susie Gilchrist</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) <b>No</b>		17. INFORMANT ADDRESS <b>Wash., D.C.</b>	
16. SOCIAL SECURITY NO. <b>578-28-2940</b>		17. INFORMANT <b>Mr. Willie Adams (husband)</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic &amp; Hypertensive Cardiovascular Disease.</b>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>9-23-1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>No</b>	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>9/18/66</b>			
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>9-23-1966</b>	
23C. NAME of CEMETERY or CREMATORY <b>Arlington National</b>		23D. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1966</b>		24B. NAME OF REGISTRAR <b>Charles E. Farley, M.D.</b>	
24C. FUNERAL DIRECTOR <b>MALVAN &amp; SCHEY, INC.</b>		24D. ADDRESS <b>424 R St., N. W., Washington, D. C.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 09750		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		66-09750	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>JAY RICHARDSON</b>		2. DATE AND HOUR OF DEATH <b>September 23, 1966</b>   <b>8:05p M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital 1514 Division Street Baltimore, Maryland 21217</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b>		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		D. STREET ADDRESS (If rural, give location) <b>529 E. 27th. Street</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>1-15-1905</b>	9. AGE (In years lost birthday) <b>61</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Composition Roofers</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Richardson</b>		14. MOTHER'S MAIDEN NAME <b>Janie Ingram</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>718-10-9192</b>		17. INFORMANT <b>Rose Lee Richardson-wife</b>		ADDRESS <b>Phone: 235-9296</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Epilepsy</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>From 9/20/66 to 9/23/66</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>no</b>		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>September 20, 1966</b> to <b>September 20, 1966</b> , that (I) (we) last saw the deceased alive on <b>September 20, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Ata Amini</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>September 24, 1966</b>					
23C. PHYSICIAN'S NAME (Type) <b>Ata Amini</b>		23D. ADDRESS <b>1514 Division Street-Baltimore 17, Maryland</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-28-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A.A. Co., Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Marshall W. Jones, Jr., 1735 Harford Ave.</b>		ADDRESS			

September 2, 1966

Maryland

Baltimore

200 E. Enoch Avenue

61

Baltimore, Maryland

Unknown

new Lee monogram-style

no

no

September 2, 1966

66

September 2, 1966

66

September 2, 1966

x

1966-1967

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2-525

66 09751

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09751

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		EDWARD THOMAS JENKINS		2. DATE AND HOUR PRONOUNCED DEAD		September 26, 1966		9:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION  1819 Harford Ave.				A. STATE Maryland					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY					
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)					
				Baltimore					
				D. STREET ADDRESS (If rural, give location)					
				1802 Hope Street					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
Male	Negro	Single	3-26-26	40					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer						Baltimore, Md.		U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			ADDRESS			
William C. Jenkins			Georgia Brown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			
yes			214-20-9191			William Jenkins 1304 SPRING ST.			
18. CAUSE OF DEATH								INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)									
(A) Intrapontine hemorrhage									
DUE TO									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.									
(B) DUE TO									
(C)									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				Yes		Yes			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type)		Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		September 26, 1966			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)			
Burial		9-30-66		Baltimore National		Baltimore, Maryland			
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS			
SEP 28 1966		Robert E. Farber, M.D.		Marshall W. Jones, Jr.		1735 Harford Ave.			

WALFORD

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William F. Walford

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09752				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 09752	
1. NAME OF DECEASED (Type or Print) <b>EICHER, PEARL E.</b>				2. DATE AND HOUR OF DEATH <b>9-26-66</b>		12:05P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL</b>				A. STATE <del>MARYLAND</del> <b>PENNSYLVANIA</b>					
(If not in hospital or institution, give street address or location)				B. COUNTY					
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <del>BALTIMORE</del> <b>CONNELLSVILLE, K-35</b>					
				D. STREET ADDRESS (If rural, give location) <del>6808 WASHINGTON BLVD</del> <b>911 ROCKRIDGE RD.</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>11-03-00</b>		9. AGE (In years last birthday) <b>65</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>EDWARD LEISH</b>				14. MOTHER'S MAIDEN NAME <b>IDA SHUNKWILER</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>CATON AVES. 21229 ST AGNES HOSPITAL RECORDS, WILKINS AND</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMA ORIGINATING LEFT KIDNEY - METASTATIC</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>? MONTHS</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO					
				(B) DUE TO					
				(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>NONE</b>					
19A. DATE OF OPERATION <b>8/18/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Left Renal Mass - Biopsied</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>9-14-66</b> to <b>9-26-66</b> that (I) (we) last saw the deceased alive on <b>9-26-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>W. E. Signor M.D.</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/26/66</b>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/29/66</b>		24C. NAME of CEMETERY or CREMATORY <b>NORMAVILLE, CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>FAYETTE CO., PENNSYLVANIA</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1966</b>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, MA</i>		25C. FUNERAL DIRECTOR <b>HOWARD H. HUBBARD</b>		ADDRESS <b>4107 WILKENS AVE. 21229</b>			

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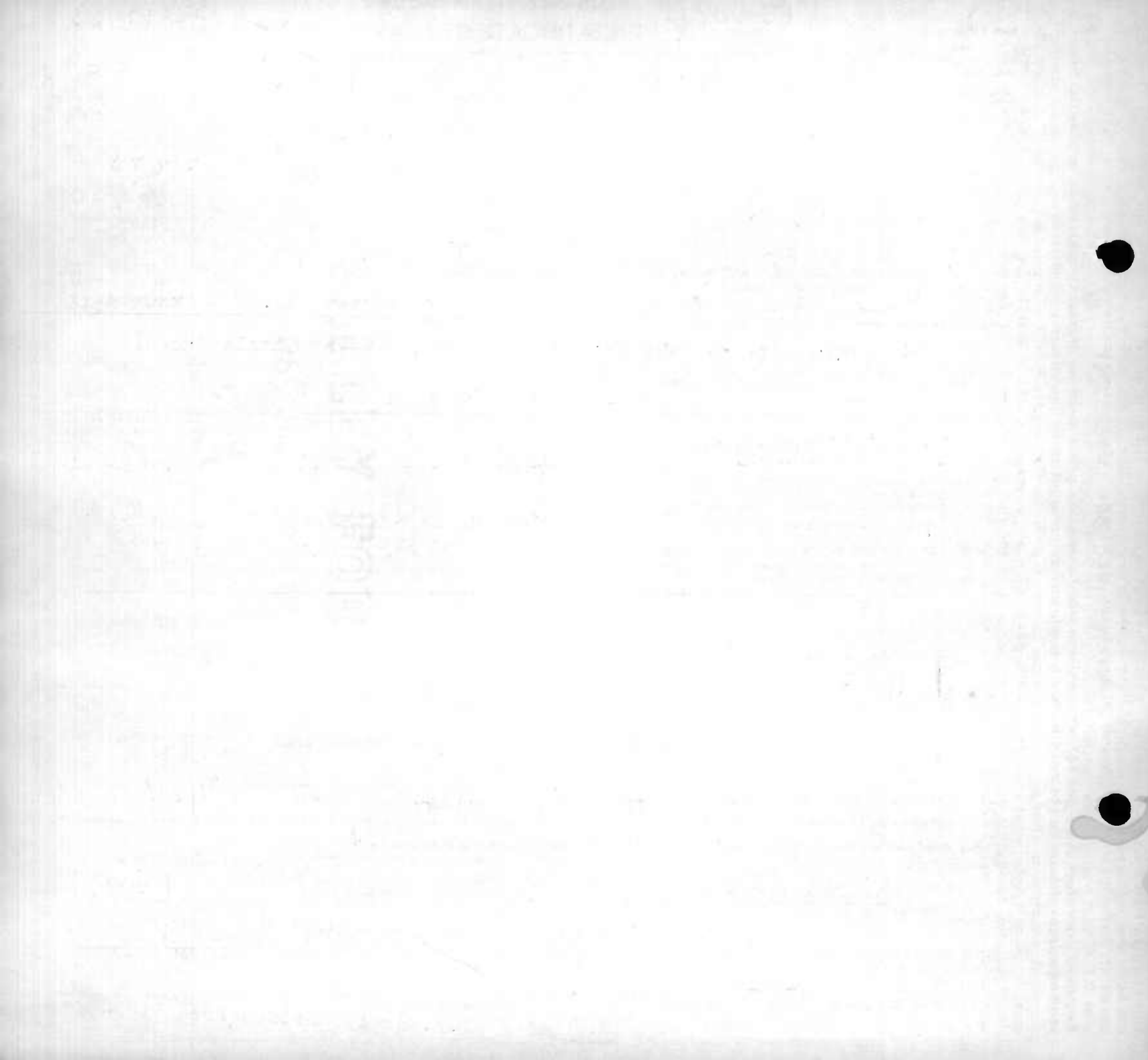
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
66 09753					CERTIFICATE OF DEATH					Registered No. 335-511-7598									
BIRTH NO.										M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) King, Helen										2. DATE AND HOUR OF DEATH 9/24/66 5:30 A.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY									
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital										C. CITY OR TOWN (If outside city limits, write RURAL and give township) PRINCE FREDERICK 20678									
										D. STREET ADDRESS (If rural, give location) 54-00									
5. SEX Female		6. RACE NEGRO		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH 9/24/24		9. AGE (In years lost birthday) 42		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY -					11. BIRTHPLACE (State or foreign country) XXXXXXXXXX Md.					12. CITIZEN OF WHAT COUNTRY? USA XXXXXXXXXX				
13. FATHER'S NAME No XXXX XXXXX John Chase										14. MOTHER'S MAIDEN NAME XXXXXXXXXX Minnie Mackall									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 220-38-3145					17. INFORMANT Admission Record					ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I 151X CAUSE OF DEATH (A) Gastric hemorrhage DUE TO (B) Carcinoma of stomach DUE TO widespread (C)										INTERVAL BETWEEN ONSET AND DEATH unknown unknown									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION 9/22					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gastric hemorrhage					20A. AUTOPSY? (Yes or No) NO					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None					21C. WHERE DID INJURY OCCUR? →					(If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) none					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR? →									
22. I certify that (I) (this hospital) attended the deceased from 9/20 1966 to 9/24 1966, that (I) (we) last saw the deceased alive on 9/24 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.																			
23A. SIGNATURE Fred R. Eilber M.D.										Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED 9/24				
23C. PHYSICIAN'S NAME (Type) Fred R. Eilber M.D.					23D. ADDRESS University Hospital														
24A. BURIAL CREMATION, REMOVAL (Specify) 9-28-66					24B. DATE 9-28-66					24C. NAME of CEMETERY or CREMATORY Youngs C. Cem					24D. LOCATION (City, town, or county) (State) Huntingtown Md				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR J. E. Sewell					25C. FUNERAL DIRECTOR P. E. Sewell					ADDRESS Prince Frederick-Md				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09754</u>	
BIRTH NO. <u>66 09754</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>EMMA L. ZIMMERMAN</u>		2. DATE AND HOUR OF DEATH <u>SEPT. 25, 1966</u>   <u>8<sup>30</sup> A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL</u>		A. STATE <u>MD</u> B. COUNTY <u>BALTO</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO. MD.</u>			
		D. STREET ADDRESS (If rural, give location) <u>359 S. CORNWALL ST</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JULY 23, 1894</u>	9. AGE (In years last birthday) <u>75</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>	
13. FATHER'S NAME <u>ADOLPH GRIFFNER</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE JACOB</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>CHAS. E. ZIMMERMAN</u>	
				ADDRESS <u>339 S. CORNWALL</u>	
18. <u>416X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>Chronic congestive heart failure</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
		(B) <u>RHEUMATIC HEART DISEASE</u> DUE TO		<u>50 years.</u>	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NONE</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 24</u> 19 <u>66</u> to <u>SEPT. 25</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>SEPT 25</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James A. Quinlan, Jr.</u> M.D.				23B. DATE SIGNED <u>SEPT 25, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>JAMES A. QUINLAN, JR.</u> M.D.				23D. ADDRESS <u>MERCY HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>SEP 28 1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>OAK LAWN</u>	
				24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Connelly F. H.</u> ADDRESS <u>300 Mace Ave.</u>	

July 13 1904

Charles D. Judd

Robert Griffith

Chas. E. Zimmerman

Chas. E. Zimmerman

Chas. E. Zimmerman

Chas. E. Zimmerman

Chas. E. Zimmerman

Chas. E. Zimmerman

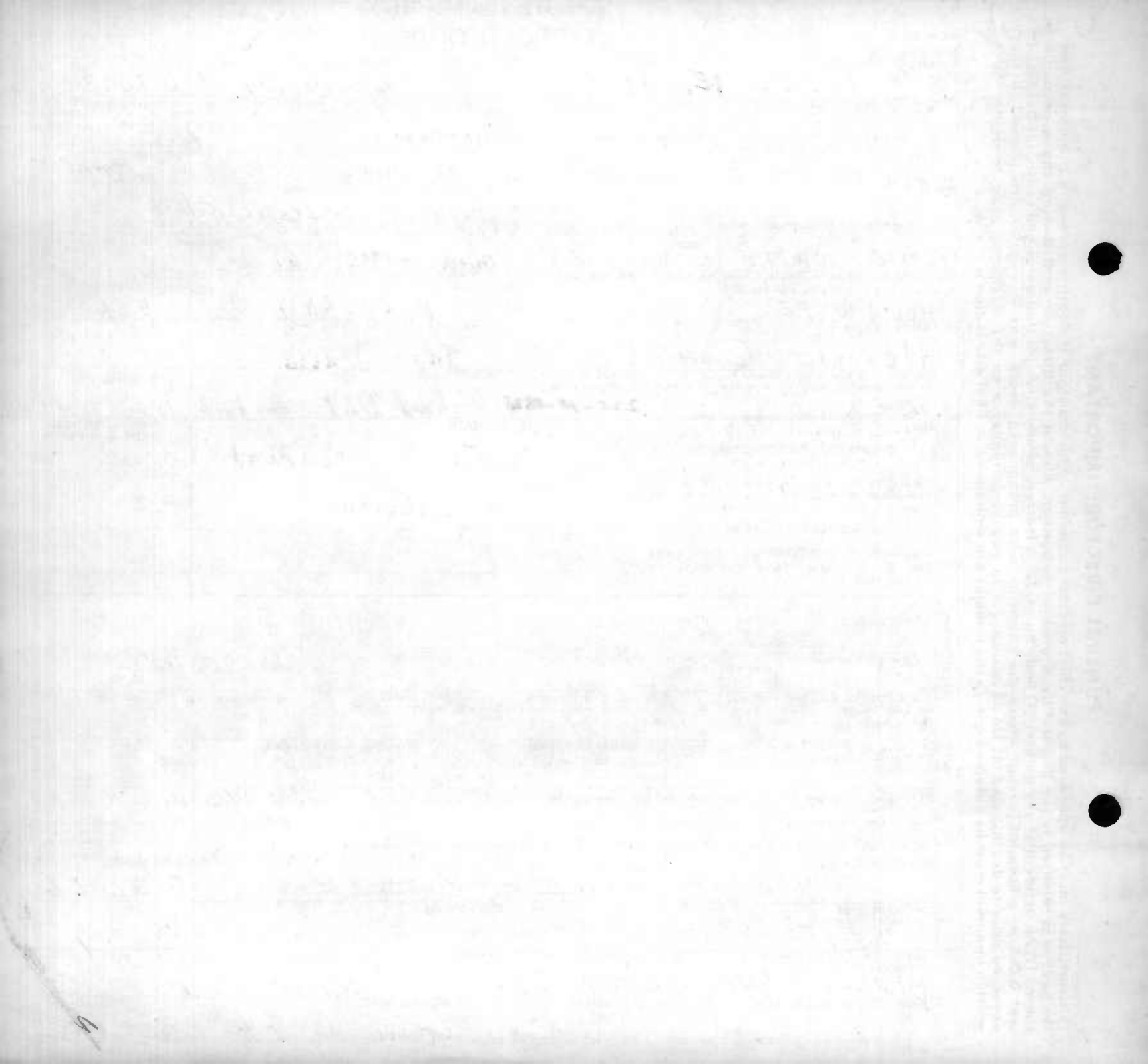
Chas. E. Zimmerman

Chas. E. Zimmerman

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 09755		66 09755		66 09755	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>HAZEL M. UHL</b>			2. DATE AND HOUR OF DEATH <b>September 24, 1966 10:30 P. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>NORTH CHARLES GENERAL HOSPITAL</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
			D. STREET ADDRESS (If rural, give location) <b>Box 501C 15 Leslie Rd</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MAR. 24 1905</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Alexander Campbell</b>			14. MOTHER'S MAIDEN NAME <b>Ida Davis</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>220-10-0548</b>		17. INFORMANT <b>Richard Uhl</b>
			ADDRESS <b>Box 501C 15 Leslie Rd Balto.</b>		
18. <b>420.1 I</b>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO <b>Acute myocardial infarction</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
			(C)		
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from <b>September 24 1966</b> to <b>September 24 1966</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Melito M. Torres</b> M.D.				23B. DATE SIGNED <b>9-26-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MELITO M. TORRES</b>				23D. ADDRESS <b>441 S. ELLWOOD AVE.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/28/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>EBENEZER</b>	
24D. LOCATION <b>BALTO MD.</b>		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR <b>SEP 28 1966</b>	
24G. NAME OF REGISTRAR <b>Connolly FH.</b>		24H. ADDRESS <b>300 M...</b>		24I. FUNERAL DIRECTOR	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09756	
BIRTH NO. 66 09756		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) E. Charles Jackson		2. DATE AND HOUR OF DEATH 9-23-66 8 <sup>19</sup> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		8. COUNTY	
5804 Woodcrest Ave		C. CITY OR TOWN Baltimore		27-19	
		D. STREET ADDRESS (If rural, give location)		5804 Woodcrest Ave	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-15-15	9. AGE (In years lost birthday) 51	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10B. KIND OF BUSINESS OR INDUSTRY Restaurant Chain		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles M. Jackson		14. MOTHER'S MAIDEN NAME Mildred Steinfirst	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 156-09-0134		17. INFORMANT ADDRESS Virginia B Jackson 5804 Woodcrest Ave	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Due to Accute myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 10 months	
ANTECEDENT CAUSES (B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-26-15 1957 to 9/23/66 19 that (I) (we) lost saw the deceased alive on 9/12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lester N. Kolman		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/26/66	
23C. PHYSICIAN'S NAME (Type) LESTER N. KOLMAN		23D. ADDRESS 3700 Park Heights Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-27-66		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cem.	
24D. LOCATION (City, town, or county) (State) Pikesville, Balt Co Md		25A. DATE REC'D BY HEALTH DEPT. SEP 28 1966		25B. NAME OF REGISTRAR E. E. Jackson	
25C. FUNERAL DIRECTOR		25D. ADDRESS 3631 Falls Rd			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09757	
BIRTH NO. 66 09757		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARGARET CAROLINE SANDRUCK		2. DATE AND HOUR OF DEATH 9/23/66	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Carroll		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Convalesarium		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rural - Millers		56-00	
D. STREET ADDRESS (If rural, give location)		5. SEX Female		6. RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married		8. DATE OF BIRTH 7/25/12		9. AGE (In years lost birthday) 54	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothing factory employee		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles F. Sandruck		14. MOTHER'S MAIDEN NAME Elizabeth Cornbower			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-20-8812		17. INFORMANT ADDRESS Mrs. Orrin Kaste, Bel Air, Md.	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Carcinoma of Colon		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1966 to Sept 23 1966, that (I) last saw the deceased alive on Sept 23, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.		23A. SIGNATURE Emmett P. Davis M.D.		23B. DATE SIGNED 9/25/66	
23C. PHYSICIAN'S NAME (Type) m Emmett P. Davis M.D.		23D. ADDRESS 5317 Belair Road Baltimore, Maryland 21206			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/27/66		24C. NAME OF CEMETERY OR CREMATORY Manchester Cemetery	
24D. LOCATION Manchester				Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 28 1966		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Tipton-Eline	
				ADDRESS Hampstead, Md.	





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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09759		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09759	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ANNIE Tuel			2. DATE AND HOUR OF DEATH 9-24-66 9:45 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Baltimore, Md. FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Virginia, Culpepper B. COUNTY C. CITY OR TOWN Route 2, Culpepper D. STREET ADDRESS Route 2		
5. SEX F	6. RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 7-28-98	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Oscar Spicer		
14. MOTHER'S MAIDEN NAME Fink			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		
16. SOCIAL SECURITY NO. P			17. INFORMANT ADDRESS Hospital Records		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Coronary heart disease (B) old hemorrhage, unrelieved pneumonia (C) congested CHF		
19. DATE OF OPERATION 9-20-66			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ROBERTO G. ARELLANO			23B. DATE SIGNED 9/25/66		
23C. PHYSICIAN'S NAME (If any) ROBERTO G. Arellano			23D. ADDRESS SOUTH BALT. GEN. Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-28-66		24C. NAME of CEMETERY or CREMATORY FAIRVIEW	
24D. LOCATION (City, town, or county) VA. Culpepper		24E. STATE VA.		24F. ADDRESS 7101 Fairview Ave	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 28 1966		G. E. Johnson		W. Miller	

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# FUNERAL DIRECTOR: IMPORTANT

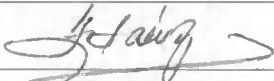
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

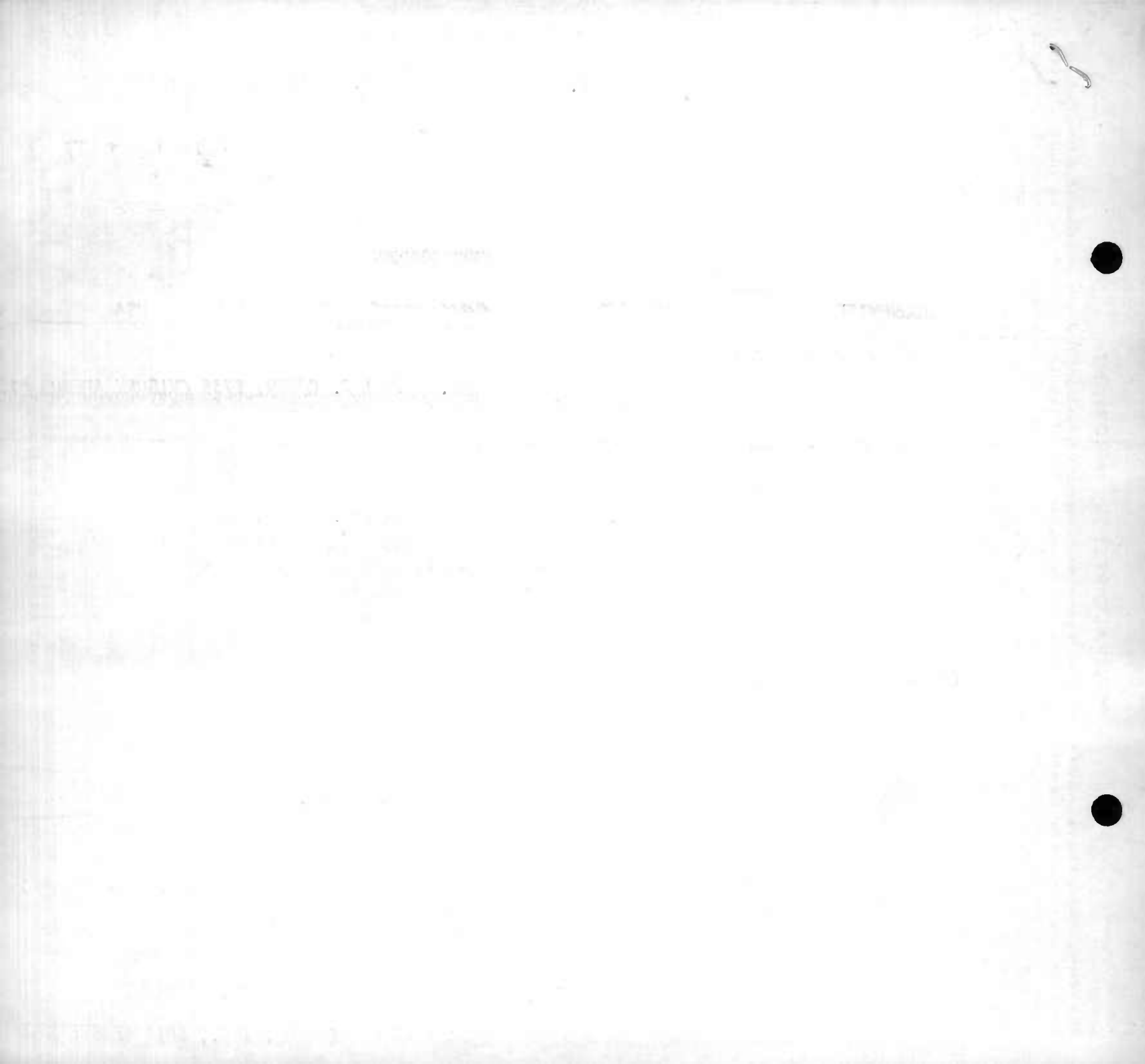
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09760	
BIRTH NO. 66 09760				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ISRAEL HESS BERMAN</b>		2. DATE AND HOUR OF DEATH <b>SEPTEMBER 25-66 7 35 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 SINAI HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>5118 CHALGROVE AVE (21215)</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>XXXXXX</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DEALER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SCRAP</b>		11. BIRTHPLACE (State or foreign country) <b>CHARLESTON, WEST VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>MEYER BERMAN</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-07-0424</b>		17. INFORMANT <b>MRS. ETHEL BERMAN, 5118 CHALGROVE AVENUE #15</b>	
18. <b>332 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH.</b>		(A) DUE TO		(B) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 10 YRS.</b> <b>CHRONIC OBSTRUCTIVE PULMONARY EMPHYSEMA 10 YRS.</b>		19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 10 YRS.</b>	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>AUGUST 26</b> 19 <b>66</b> to <b>SEPT. 25</b> 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>SEPT. 25</b> 19 <b>66</b> , and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Howard H. Gendason</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9/25/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>HOWARD H. GENDASON</b>		23D. ADDRESS M.D. <b>11969 REISTERSTOWN RD. REISTERSTOWN MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/27/66</b>		24C. NAME of CEMETERY or CREMATORY <b>BNAI ISRAEL</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbot</b>		25C. FUNERAL DIRECTOR <b>SOL LEY IN SON &amp; BROS. INC., 6010 REISTERSTOWN</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09761</b>
BIRTH NO. <b>66 09761</b>		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Cohen, Reba B.</b>		2. DATE AND HOUR OF DEATH <b>SEPT-25-1966 4:55 PM</b>
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
		D. STREET ADDRESS (If rural, give location) <b>2735 EYEBURN AVE. #15</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MARCH 1936</b>	9. AGE (In years lost birthday) <b>70</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Salomon Baron</b>		14. MOTHER'S MAIDEN NAME <b>Jenny Baron Chien</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-48-5541</b>	17. INFORMANT <b>MR. SAMUEL C. COHEN, 2735 EYEBURN AVENUE, #15</b>	
18. <b>170X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> 1 - <b>Respiratory cardiac arrest.</b> 2 - (A) <b>due to Ventricular Fibrillation.</b> DUE TO 3 - (B) <b>Myocardial Infarction &amp; Pulmonary edema.</b> DUE TO 4 - <b>congestive heart failure.</b> 5 - (C) <b>Neoplasm of the lung (2), probably metastases from CA. of the Breast.</b>		INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		5 -		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <b>JUN - 1964</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CA. OF L Breast. (mastectomy)</b>	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>-</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>SEPT-6 1966</b> to <b>SEPT 19 66</b> , that (I) (we) last saw the deceased alive on <b>SEPT-25 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>SEPT-25-1966</b>
23C. PHYSICIAN'S NAME (Type) <b>FRANCISCO SAENZ</b>		23D. ADDRESS <b>SINAI HOSPITAL HOUSE STAFF</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>9/26/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>AGUDAS ACHIM ANSHE SFARD</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 09762</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>66 09762</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>BLANCHE BEATRICE RASHOFF</b>			2. DATE AND HOUR OF DEATH <b>9/25/66</b> <b>4:30 P</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSP</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2526 PELLIM RD # 9</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>XXXXXXXXXX</b>	9. AGE (In years lost birthday) <b>50</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>XXXXXXXXXX</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CLERICAL OFFICE</b>	11. BIRTHPLACE (State or foreign country) <b>Id.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>XXXXXXXXX RASHOFF (dec.)</b>			14. MOTHER'S MAIDEN NAME <b>Ida XXXXXXXX (dec.) PEREGOFF</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-12-4511</b>	17. INFORMANT <b>RECORDS</b>		ADDRESS
18. <b>193.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ostehenia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL NEOTLASH</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HERNIATION of BRAIN STEM</b>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/13/66</b> 19 <b>66</b> to <b>9/25</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/25</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Arnoldo Schupak</b>			23B. DATE SIGNED <b>9/25/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>ARNOLDO SCHUPAK M.D.</b>			23D. ADDRESS <b>UNIVERSITY HOSP</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>9/26/66</b>	24C. NAME of CEMETERY or CREMATORY <b>HEBREW FRIENDSHIP</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1966</b>		25B. NAME OF REGISTRAR <b>P. E. F. J. J.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</b>	

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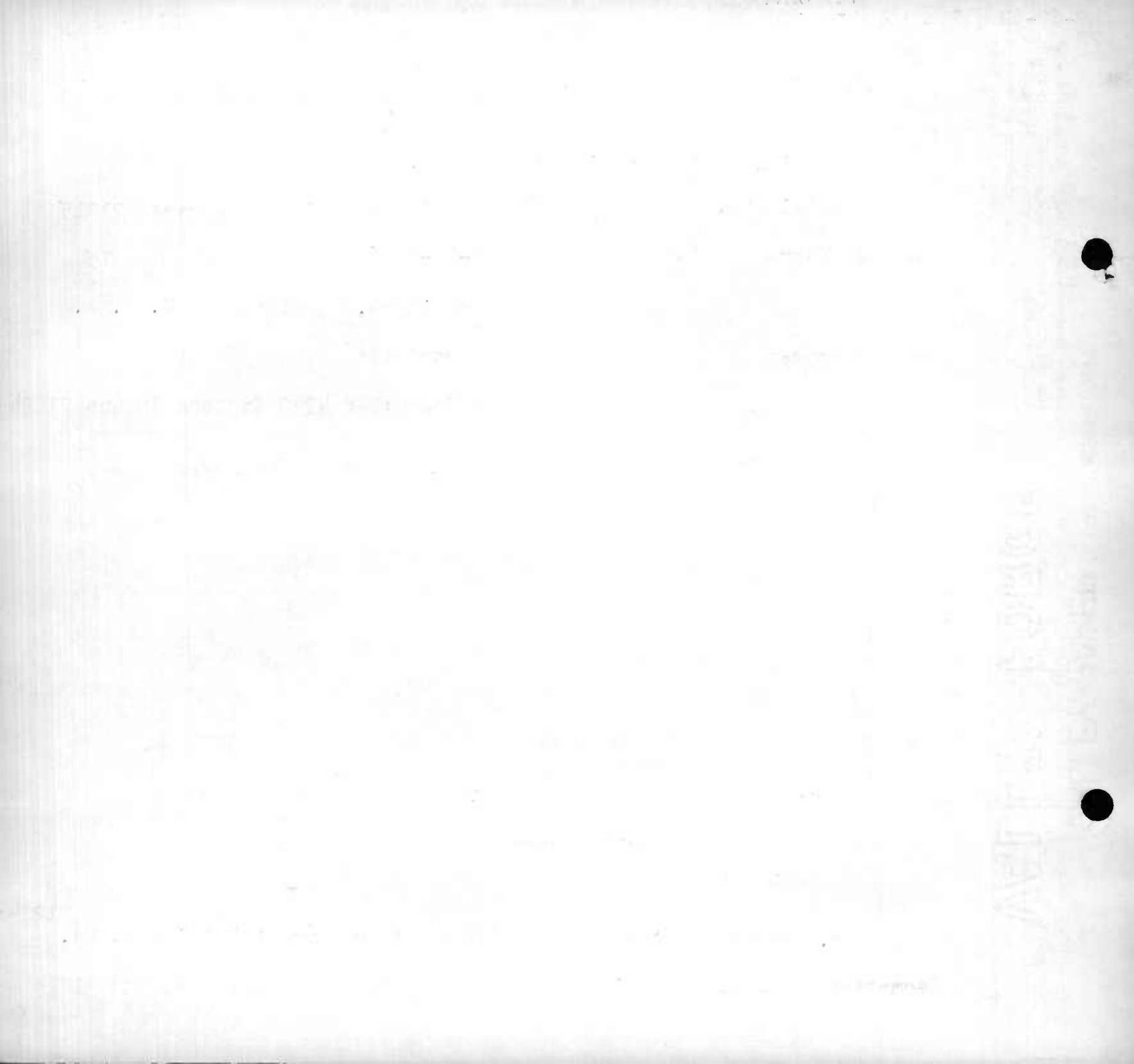
47-69-62  
FRS12 66 19210  
66 09763BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 4768 09763

M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Thompson, Girl "A" Henrietta</i>		9-13-66 1 7 <sup>36</sup> P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>2516 Park Heights Terrace 21215</i>	
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>NEVER MARRIED</i>	8. DATE OF BIRTH <i>7-12-1966</i>
9. AGE (In years last birthday)		10. AGE (In years last birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Amos Thompson</i>		14. MOTHER'S MAIDEN NAME <i>Henrietta</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS <i>RECORDS: BCH 4940 Eastern Avenue 21224</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Respiratory distress synd.</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>prematurity</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that <del>at</del> (this hospital) attended the deceased from <i>9-12</i> 19 <i>66</i> to <i>9-13</i> 19 <i>66</i> , that <del>at</del> (we) last saw the deceased alive on <i>9-13</i> 19 <i>66</i> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>at</del> (we) (did) ( <del>not</del> ) view the body after death.			
23A. SIGNATURE <i>Dr. Munzer Haddian</i>		23B. DATE SIGNED <i>9-13-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Munzer Haddian</i>		23D. ADDRESS <i>4940 Eastern Avenue Baltimore, Md. 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>9-14-66</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Baltimore City Hospitals</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland 21224</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 28 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i>		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>563266 09764</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>66 09764</b>	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>NANCE SWARTZ</b>			<b>SEPTEMBER 24 1966 7<sup>25</sup> A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE, INC</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>Carroll</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>SYKEVILLE 56-00</b>		
			D. STREET ADDRESS (If rural, give location) <b>16 CARROLL HIGHLAND</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4-18-31</b>	9. AGE (In years lost birthday) <b>35</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD</b>	
13. FATHER'S NAME <b>Charles Merker</b>		14. MOTHER'S MAIDEN NAME <b>Florence Kalal</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-28-6976</b>		17. INFORMANT <b>Harry B. Swartz</b>	
				ADDRESS <b>16 Carroll Highland Sykesville Md</b>	
18. I <b>170X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <b>CARCINOMA OF BREAST - TERMINAL</b> DUE TO <b>2 years</b> <b>WITH WIDESPREAD METASTASES</b>		
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>9-11-66</b> 19 <b>66</b> to <b>9-24</b> 19 <b>66</b> . that (I) <b>(we)</b> last saw the deceased alive on <b>9-24</b> 19 <b>66</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> <b>(We)</b> <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Melvyn B. Lewis</b>				23B. DATE SIGNED <b>9-24-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MELVYN B. LEWIS</b>				23D. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<b>Buried</b>		<b>9/26/66</b>		<b>Lakeriew Memorial</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>SEP 28 1966</b>		<b>Robert E. Taylor</b>		<b>Spring Byers</b>	
				ADDRESS <b>8728 Liberty Rd Randallstown Md</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

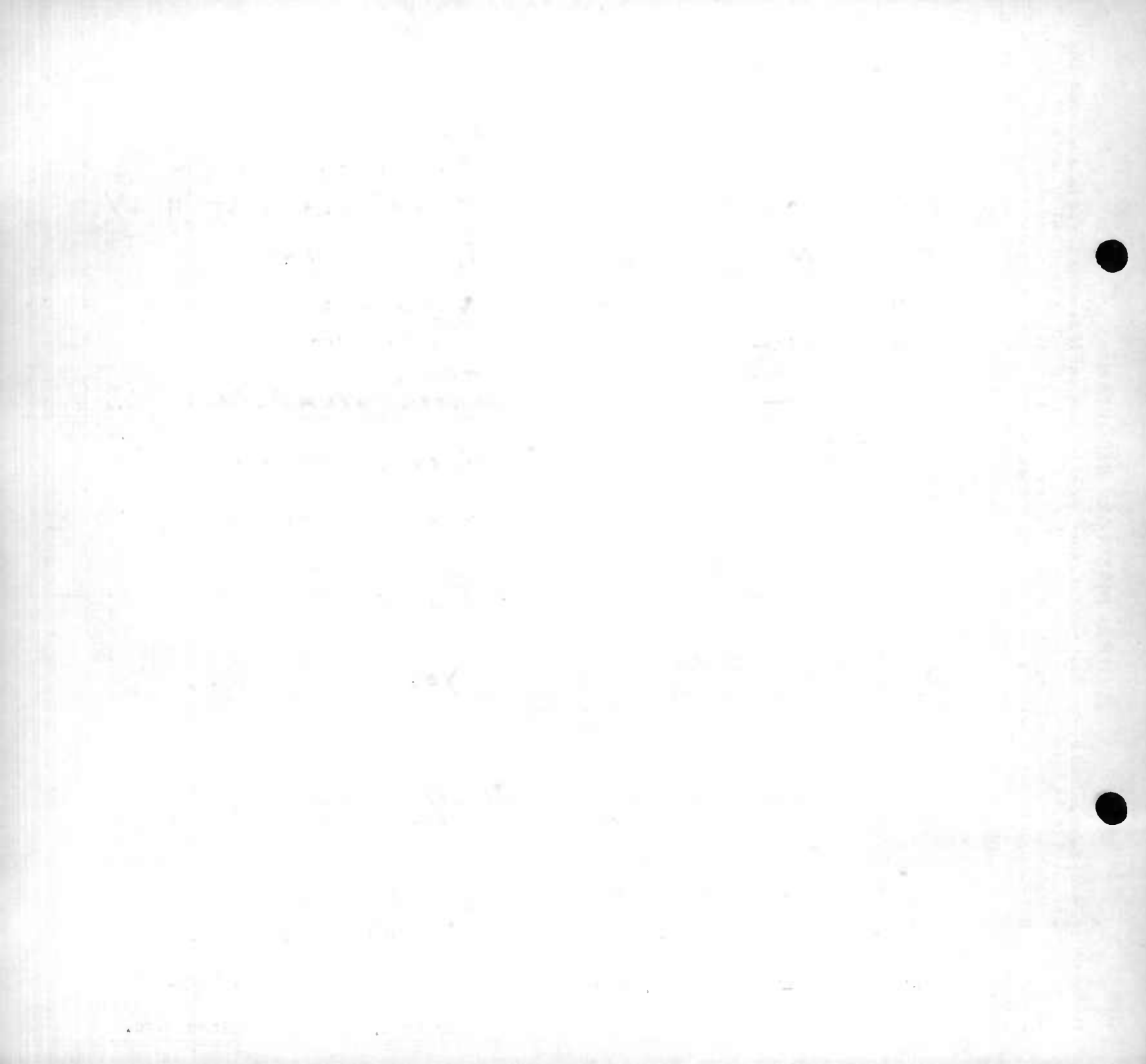
BIRTH NO. 66 09765		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09765	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) STEVENS, JAMES A.		2. DATE AND HOUR OF DEATH 9/25/66 8:15 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21207		53-00	
		D. STREET ADDRESS (If rural, give location) 3606 Kenmar RD			
5. SEX male	6. RACE white	MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 8/25/89	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Retired (Furniture)		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Daniel Stevens		14. MOTHER'S MAIDEN NAME Emma Wright	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 184-01-1352		17. INFORMANT Mrs Carrye R. Stevens	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Uremic coma (B) DUE TO Diabetes (C)		INTERVAL BETWEEN ONSET AND DEATH 9/8/66 - 9/25/66	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 9/8/66 to 9/25/66 that (we) last saw the deceased alive on 9/24/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. R. J. Aie		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/25/66	
23C. PHYSICIAN'S NAME (Type) IRAE REJAIE		23D. ADDRESS LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/28/66		24C. NAME of CEMETERY or CREMATORY Lind Ridge	
24D. LOCATION (City, town, or county) (State) Pikesville 8 Md		25A. DATE REC'D BY HEALTH DEPT. SEP 28 1966		25B. NAME OF REGISTRAR G. E. Taylor	
25C. FUNERAL DIRECTOR Spring Byers		25D. ADDRESS Randallstown Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 09767	
BIRTH NO. 66 09767		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ALICE COCKRELL		2. DATE AND HOUR OF DEATH 9/25/66 4:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 13-02			
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 821 WHITELOCK ST # 17			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 7/15/93	9. AGE (In years lost birthday) 73	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HW		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Ernest Gaskins		14. MOTHER'S MAIDEN NAME Martha Carter	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT DAUGHTER VERA Mc LAURN	
				ADDRESS 2477 CALLOW AVE #17	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I Septicemic Shock		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 Days	
I (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO		7 Days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) CS	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/23/1966 to 9/25/1966, that (I) (we) last saw the deceased alive on 9/25/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eduardo Hidalgo		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) EDUARDO HIDALGO		M.D.		23D. ADDRESS Sinai Hospital BALT, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-30-66		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 28 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles R. Law	
				ADDRESS 802 Madison Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09768		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09768	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>WILLIAM E. HOOVER</b>			2. DATE AND HOUR OF DEATH <b>SEPT 25, 1966 1 50 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 7-03</b> D. STREET ADDRESS (If rural, give location) <b>819 N. BRADFORD St.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4-11-04</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GUARD</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>WESTERN ELECTRIC</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>EDWARD E. HOOVER</b>		
14. MOTHER'S MAIDEN NAME <b>SADIE E. WILSON</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>217-07-2289</b>			17. INFORMANT <b>Mrs. Frances M. Hoover</b> <b>WIFE</b> ADDRESS <b>- 819 N. BRADFORD.</b>		
18. <b>190-9-1260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>MELANOMATOSIS</b> DUE TO (B) <b>MALIGNANT MELANOMA</b> DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 Mos.</b>			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ASCVD, Diabetes Mellitus.</b>			20. MEDICAL CERTIFICATION		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-20-66</b> 1966 to <b>9-25</b> 1966, that (I) (we) last saw the deceased alive on <b>9-25</b> 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Nina Rawlings</b>				23B. DATE SIGNED <b>9/25/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>NINA RAWLINGS</b>				23D. ADDRESS M.D. <b>MD. GENERAL Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-28-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1966</b>			
25B. NAME OF REGISTRAR <b>R. E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Stanley Miller</b>		ADDRESS <b>- 2334 Jefferson St.</b>	

EDWARD E. HILL  
SIR: I have the honor to acknowledge the receipt of your letter of the 11th inst. in relation to the matter of the above named case. I am sorry that I am unable to give you a more definite answer at this time, but I am sure that you will understand the necessity of this delay. I am, Sir, very respectfully,  
Yours truly,  
W. H. HARRIS  
JUL 11 - 04

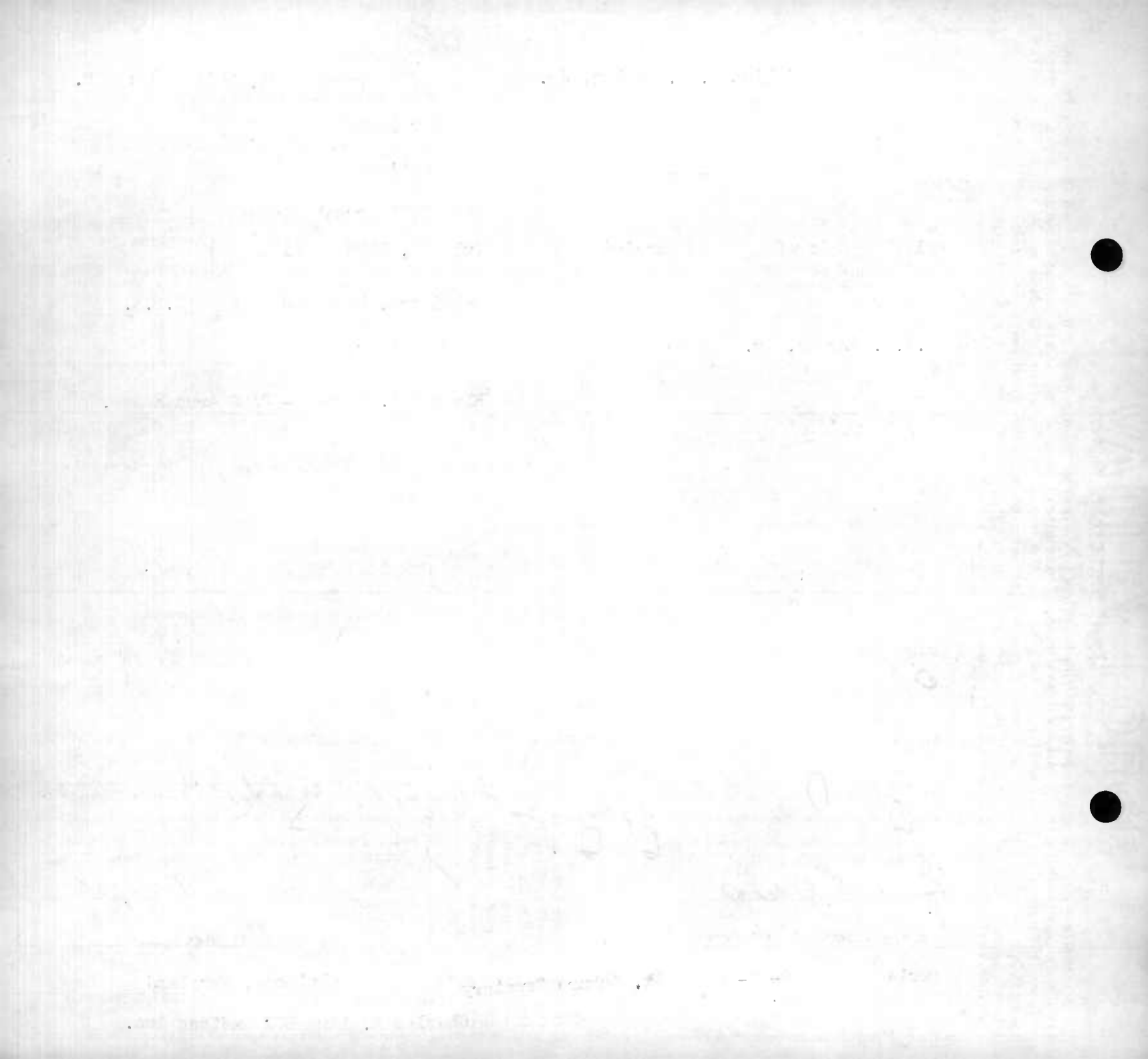
EDWARD E. HILL  
JUL 11 - 04

W. H. HARRIS  
JUL 11 - 04

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 09766</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09766</b>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
<b>William A. C. Hughes, Jr.</b>		<b>September 24, 1966</b>		<b>12:30 P.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
<b>2400 Arunah Avenue</b>		<b>Maryland</b>		<b>16-05</b>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		<b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location)			
		<b>2400 Arunah Avenue</b>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
<b>Male</b>	<b>Colored</b>	<b>Married</b>	<b>July 24, 1905</b>	<b>61</b>	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<b>Lawyer</b>				<b>Baltimore, Maryland</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<b>W.A.C. Hughes, Sr.</b>		<b>Mary Butler</b>		<b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<b>No</b>				<b>Blanche D. Hughes - 2400 Arunah Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <b>Carcinoma of the Esophagus</b> DUE TO		<b>6 months</b>	
		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<b>0</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>February 1, 1966</b> to <b>September 24, 1966</b> , that (1) (we) last saw the deceased alive on <b>September 24, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
<b>Emerson R. Julian</b>				<b>9/27/66</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<b>EMERSON R. JULIAN</b>		<b>2329 Arunah Avenue</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<b>Burial</b>		<b>9-29-66</b>		<b>St. Auburn Cemetery</b>	
				<b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<b>SEP 28 1966</b>		<b>Robert E. Taylor</b>		<b>Charles R. Law 802 Madison Ave.</b>	

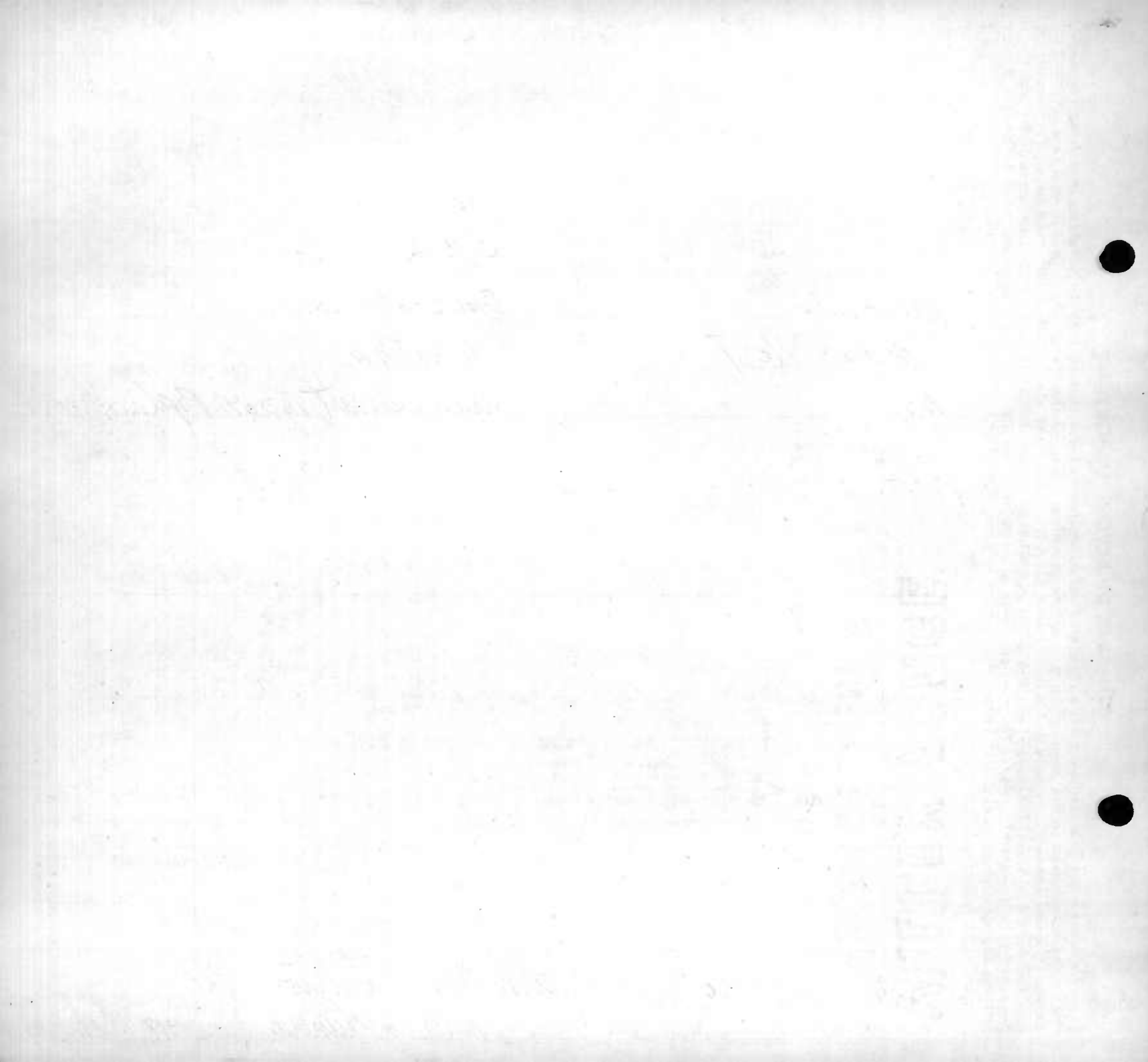




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">66 09769</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 1.5em;">66 09769</span>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Oliva Barrett</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">9/24/66</span> <span style="float: right;">7:25 P.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.5em;">Lutheran Hospital</span>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore 16-07</span>		
D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">1520 - Poplar Grove St.</span>					
5. SEX <span style="font-size: 1.2em;">Fe</span>	6. RACE <span style="font-size: 1.2em;">Negroe</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">5/16/18</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">54</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Gloucester Va.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Thomas West</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Martha</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.2em;">Kermon Barrett</span>	
18. <span style="font-size: 1.5em;">600.0 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Hemolytic Anemia with Jaundice</span> DUE TO (B) <span style="font-size: 1.2em;">Gram Negative Septicemia</span> DUE TO (C) <span style="font-size: 1.2em;">Pyelonephritis</span>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">September 24, 1966</span> to <span style="font-size: 1.2em;">September 24, 1966</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">September 24, 1966</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Robert C. Blackmon</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">9/25/66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Robert C. Blackmon</span>				23D. ADDRESS <span style="font-size: 1.2em;">Lutheran Hospital</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">9/29/66</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Mt. Auburn Cem.</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Balto Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">SEP 28 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Williams Funeral Home</span>		25D. ADDRESS <span style="font-size: 1.2em;">317 N. Schroeder</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 09770</span>	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <span style="font-size: 1.5em;">66 09770</span></p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <b>HEISCHMAN, Lester Ranch</b></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <b>September 27, 1966 10:10 A</b> M.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>Veterans Administration Hospital            3900 Loch Raven Boulevard            Baltimore, Maryland 21218</b></p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)            A. STATE <b>Maryland</b>            B. COUNTY <b>Balto</b>            C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>            D. STREET ADDRESS (If rural, give location) <b>8102 Oakleigh Road</b></p>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>7/11/10</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months: Days:    If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Industrial</b>	11. BIRTHPLACE (State or foreign country) <b>New Albany, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>George A. Heischman</b>			14. MOTHER'S MAIDEN NAME <b>Viola A. Ranck</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 9/8/43 - 11/14/45</b>		16. SOCIAL SECURITY NO. <b>299-10-79-27</b>	17. INFORMANT ADDRESS <b>VA Hospital Records Baltimore, Maryland 21218</b>		
<p>18. <b>762.1 I</b> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH            (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>Cerebral Metastases</b>            (A) DUE TO</p> <p>INTERVAL BETWEEN ONSET AND DEATH  <b>2 to 3 months</b></p> <p>ANTECEDENT CAUSES  <b>Bronchogenic Carcinoma</b>            (B) DUE TO</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>1 year</b>            (C)</p>					
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 5th 19 66</b> to <b>September 27th 19 66</b>, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>September 27th 19 66</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.</p>					
23A. SIGNATURE  <b>D. EDWARDS SMITH</b>				23B. DATE SIGNED <b>September 27, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>D. EDWARDS SMITH</b>		23D. ADDRESS <b>Veterans Administration Hospital 3900 Loch Raven Blvd., Balto., Md 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/1/66.</b>	24C. NAME OF CEMETERY or CREMATORY <b>Maplewood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>New Albany, Ohio</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc, Balto. Md. 21214</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09771				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09771	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Kostas J. Zaharis</u>				2. DATE AND HOUR OF DEATH <u>9-26-66</u> <u>4:35 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital at institution, give street address or location)  <u>37 Mercy Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-16</u> D. STREET ADDRESS (If rural, give location) <u>3010 Wylie Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Oct. 21, 1889</u>	9. AGE (In years last birthday) <u>76</u>	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Restuarant Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Zaharis</u>			14. MOTHER'S MAIDEN NAME <u>Nd Known</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>216-32-4982</u>			17. INFORMANT <u>Mr. John K. Zaharis Balto., Md.</u>				ADDRESS
18. <u>153.8</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <u>Cerebrovascular accident</u> DUE TO (B) <u>Myocardial Infarction</u> DUE TO (C) <u>Coronary of the Heart</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 days</u> <u>6 months</u> <u>8 years</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3:35 PM 9/26/66</u> 19 <u>66</u> to <u>4:35 PM 9/26</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/26/66</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
22A. SIGNATURE <u>James A. Quinlan, Jr.</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		22B. DATE SIGNED <u>Sept 26, 1966</u>	
23A. PHYSICIAN'S NAME (Type) <u>JAMES A. QUINLAN, JR</u>				23D. ADDRESS <u>MERCY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/29/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greek Orthodox Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Salyer, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc., Balto., Md.</u>		ADDRESS <u>21214</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <b>66 09772</b>	
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>  <b>M.E. CASE NO.</b>  <b>1. NAME OF DECEASED</b>                      (Type or Print) <b>Mary Catherine Kreidler</b> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <b>9/25/66</b> <b>16:30</b> <b>P.M.</b> </div> </div>											
<b>3. PLACE OF DEATH IN</b> <b>BALTIMORE, MARYLAND</b>  <div style="display: flex;"> <div style="flex: 1;"> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <b>University Hospital</b> </div> <div style="flex: 1;">                     (If not in hospital or institution, give street address or location)                 </div> </div>					<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <div style="display: flex;"> <div style="flex: 1;"> <b>A. STATE</b>  <b>Maryland</b> </div> <div style="flex: 1;"> <b>B. COUNTY</b>  <b>Baltimore</b> </div> </div>						
<b>5. SEX</b> <b>F</b>					<b>6. RACE</b> <b>W</b>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (specify) <b>single</b>		<b>8. DATE OF BIRTH</b> <b>9/20/66</b>		
<b>9. AGE</b> (In years last birthday) <b>5 days</b>					<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Baby</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>US</b>		
<b>13. FATHER'S NAME</b> <b>Robert Kreidler</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary C. Wolfgram</b>					<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
<b>16. SOCIAL SECURITY NO.</b>					<b>17. INFORMANT</b> <b>Robert Kreidler</b>					<b>ADDRESS</b> <b>9009 Hartford Rd</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>congenital cyanotic heart disease</b> (B) <b>complete Pulmonic Valvular stenosis</b> (C) <b>congenital defect</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5</b>  <b>5</b>  <b>5</b>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b> <b>Pulmonary Valvulopathy</b>										<b>28 hours</b>	
<b>19A. DATE OF OPERATION</b> <b>9/24/66</b>			<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>Pulmonic Stenosis</b>			<b>20. AUTOPSY? (Yes or No)</b> <b>NO</b>			<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <b>NO</b>			<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>			<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			<b>21F. HOW DID INJURY OCCUR?</b>		
<b>21D. TIME OF INJURY (APPROX.)</b> <b>—</b>			<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			<b>21F. HOW DID INJURY OCCUR?</b>			<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>9/23</b> <b>19 66</b> <b>to</b> <b>9/25</b> <b>19 66</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>9/25</b> <b>19 66</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>9/25</b> <b>19 66</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>		
<b>23A. SIGNATURE</b> <b>Christopher J. Beutel</b>								<b>23B. DATE SIGNED</b> <b>9/25/66</b>			
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Christopher J. Beutel</b>								<b>23D. ADDRESS</b> <b>University of Maryland Hosp. Balte. Md.</b>			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>			<b>24B. DATE</b> <b>9/27/66</b>			<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Holy Redeemer</b>			<b>24D. LOCATION</b> (City, town, or county) (State) <b>BALTIMORE Md</b>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>SEP 28 1966</b>			<b>25B. NAME OF REGISTRAR</b> <b>Robert E. ...</b>			<b>25C. FUNERAL DIRECTOR</b> <b>CHAS. T. EVANS &amp; Son</b>			<b>ADDRESS</b> <b>8802 Hartford Rd</b>		



Chris topher T. Bechtel



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T-520

66 09773

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09773

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Leroy  
Nelson Thomas

2. DATE AND HOUR PRONOUNCED DEAD

9/27/66 2:15 a. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6220 Everall Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 2, 1930

9. AGE (In years last birthday)

36

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Dairy Manager

10B. KIND OF BUSINESS OR INDUSTRY

Retail Food Store

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Walter F. Thomas

14. MOTHER'S MAIDEN NAME

Ruth Ruby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). If yes, give war or dates of service

Yes

1952-1956

16. SOCIAL SECURITY NO.

220-24-7377

17. INFORMANT

Mrs. Ruth R. Thomas 3572 Poole Street

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Cranio-cerebral injury

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

9/26/66

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

sub- and epidural hematoma

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

3724 Glenmore Ave.

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)  
9 26 66 ?

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

fell

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/27/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

30 Sept 66

23C. NAME of CEMETERY or CREMATORY

Lorraine Park Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 28 1966

Burgee Funeral Home 3631 Falls Road

VALLEY FORGE  
BANK BUILDING

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.1. NAME OF DECEASED  
(Type or Print)

JACK FILES

2. DATE AND HOUR PRONOUNCED DEAD

September 26, 1966 8:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1927 W. Baltimore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

85

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Hammond - Marion Co. W. Va.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Files

14. MOTHER'S MAIDEN NAME

Mary Vandergrift

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War 1

16. SOCIAL  
SECURITY NO.

218-07-6385

17. INFORMANT

209 Merchant St. Fairmont, W. Va.  
Carpenter & Ford Fun'l. Home

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Pneumonia and myocardial infarct  
complicating cerebrocranial injuries

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATHII  
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Monroe and Baltimore Streets

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
Sept. 15, 1966 8:05 A. M.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 26, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

23B. DATE

Burial

9/29/1966

23C. NAME of CEMETERY or CREMATORY

Muzum Cemetery

23D. LOCATION

(City, town, or county)

Fairmont, West Virginia

24A. DATE REC'D BY HEALTH DEPT.

SEP 28 1966

24B. NAME OF REGISTRAR

P. E. E. Taylor

24C. FUNERAL DIRECTOR

Easton Funeral Home Catonsville, Md.

# VALLEY FORCE

OFFICE OF THE SHERIFF

DEPT. OF CORRECTIONS

INVESTIGATION DIVISION

STATE OF IOWA

INVESTIGATION DIVISION

INVESTIGATION DIVISION

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BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 66 09775		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09775	
M.E. CASE NO.		2. DATE AND HOUR PRONOUNCED DEAD September 26, 1966 8:30 A. M.	
1. NAME OF DECEASED (Type or Print) EZEKIEL WHITLEY		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, with RURAL and give township) Baltimore 18-02 D. STREET ADDRESS (If rural, give location) 1051 W. Lexington Street	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1051 W. Lexington Street	5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10B. KIND OF BUSINESS OR INDUSTRY Bedding	8. DATE OF BIRTH 9-28-1906	9. AGE (in years last birthday) 59
11. BIRTHPLACE (State or foreign country) North Carolina	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME Matthew Whitley	14. MOTHER'S MAIDEN NAME Angelina Whitley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Bertha Whitley	ADDRESS 1051 W. Lexington St.
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of stomach ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED September 26, 1966	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 9-30-66	23C. NAME OF CEMETERY or CREMATORY Arbutus Mem PK.	23D. LOCATION (City, town, or county) (State) Baltimore Md
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR Morton & Dgett	ADDRESS 1701 Laurens





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09776				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09776	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Nelson, Herbert George</i>				2. DATE AND HOUR OF DEATH <i>Sept 25, 1966 3:55p M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital</i>				A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore City 18-01</i>			
				D. STREET ADDRESS (If rural, give location) <i>241 N. Schroeder</i>			
5. SEX <i>M</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>8/28/07</i>	9. AGE (In years last birthday) <i>59</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during last of working life, e.g., <i>Truck Driver</i> )		10B. KIND OF BUSINESS OR INDUSTRY <i>American Ice Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George E. Nelson</i>				14. MOTHER'S MAIDEN NAME <i>Ellen Mae Curley</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unkn</i>				16. SOCIAL SECURITY NO. <i>unkn</i>		17. INFORMANT ADDRESS <i>Dorothy Nelson 241 N. Schroeder</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Myocardial Infarction</i>				INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Recurrent Pulmonary Emboli</i>				(B) DUE TO <i>Recurrent Pulmonary Emboli</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Probable Hepatic Cirrhosis</i>				(C) DUE TO <i>Post op Vena Cava (Inf) Ligation</i>			
19A. DATE OF OPERATION <i>9-24-66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Recurrent Pulmonary Emboli</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 30, 1966</i> to <i>Sept 25, 1966</i> , that (I) (we) last saw the deceased alive on <i>Sept 25, 1966</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Patrick E Brookhouse</i> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Sept 25, 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>Patrick E Brookhouse</i> M.D.				23D. ADDRESS <i>Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9-29-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. PK.</i>		24D. LOCATION (City, town, or county) (State) <i>Ba Ht. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 28 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairley</i>		25C. FUNERAL DIRECTOR <i>MORTON J. DOTT</i>		ADDRESS <i>1701 LAURENS ST.</i>	

90 7

For the above...

...

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 097777		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 097777	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>Elmira Mae Brown</b>			2. DATE AND HOUR OF DEATH <b>9-22-66 10:10 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 Sinai Hosp.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY _____		
5. SEX <b>F</b> 6. RACE <b>N</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>sep.</b>			8. DATE OF BIRTH <b>12-29-16</b>		9. AGE (in years last birthday) <b>49</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Music Teacher</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Frederick Johns</b>			14. MOTHER'S MAIDEN NAME <b>Elmira Gantt</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Elmira G. Johns; 2815 Walbrook Ave</b>
18. <b>170 X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Ca of Breast</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO _____ (B) DUE TO _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <b>1-26-66</b> 19 <b>66</b> to <b>9-22</b> 19 <b>66</b> , that <u>(I)</u> (we) lost saw the deceased alive on <b>9-22</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above <u>(I)</u> (We) (do) (did not) view the body after death.					
23A. SIGNATURE <b>Lawrence Solomon</b>				23B. DATE SIGNED <b>9-22-66</b>	
23C. PHYSICIAN'S NAME (Type) M.D.				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-27-66</b>		24C. NAME of CEMETERY or CREMATORY <b>MOUNT GUBURN</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Sisk</b>		25C. FUNERAL DIRECTOR <b>McMorton &amp; Dyett, Fun'l. H. 1701 Laurens. St</b>			

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66 09778

BALTIMORE CITY HEALTH DEPARTMENT

66 09778

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MARY

(HAZEN)

STONESIFER

2. DATE AND HOUR PRONOUNCED DEAD

September 23, 1966

1:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

City Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3409 Mt. Pleasant Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)  
separated

8. DATE OF BIRTH

7/25/18

9. AGE (In years  
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

John DiGiacomo

14. MOTHER'S MAIDEN NAME

Amelia Fischetti

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

16. SOCIAL  
SECURITY NO.

215-24-6462

17. INFORMANT

Mr. Geo. Hazen

ADDRESS

3409 Mt. Pleasant

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic heart disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 23, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9/26/66

23C. NAME OF CEMETERY or CREMATORY

St. Stanislaus Cem

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

VALLEY FOLIO

APP. 10/12/21

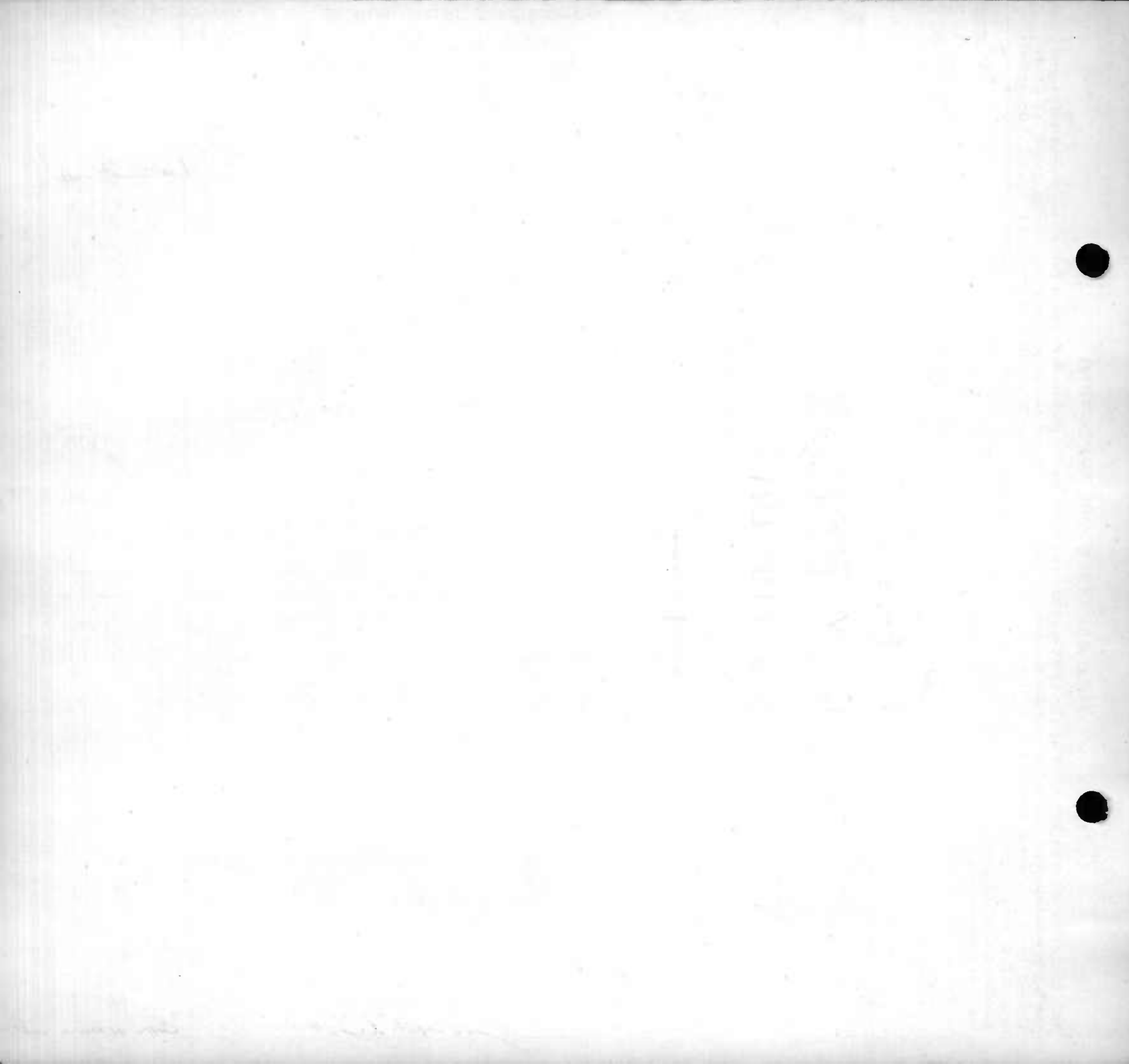
10/12/21

10/12/21

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09779		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09779	
<b>CERTIFICATE OF DEATH</b>					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ZIEGLER VERA A.		9-24-66 1230 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  MONTEBELLO S. HOSPITAL			A. STATE Md - BALTIMORE		
(If not in hospital or institution, give street address or location)			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) HARFORD GUEST HOUSE		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12-18-17	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE	
13. FATHER'S NAME CHARLES GRIFFITH		14. MOTHER'S MAIDEN NAME MARY MORROW		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-03-3531		17. INFORMANT Hospital Records	
				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH 170 X I Ca. breast with metastasis			INTERVAL BETWEEN ONSET AND DEATH 1959-1966		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1959		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA. rupt heart		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/23/66 to 9/24/66 that (I) (we) last saw the deceased alive on 9/24/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert Folgueras				23B. DATE SIGNED 9-24-66	
23C. PHYSICIAN'S NAME (Type) ALBERT FOLGUERAS				23D. ADDRESS 671 BRISBANE RD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept 28, 1966		24C. NAME OF CEMETERY or CREMATORY Mt Carmel Cem	
24D. LOCATION Baltimore		24E. NAME OF REGISTRAR Robert E. Talbot		24F. FUNERAL DIRECTOR Joseph L. Zannone	
25A. DATE REC'D BY HEALTH DEPT. SEP 28 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS 2635 Conkling St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09780</b>	
BIRTH NO. <b>66 09780</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>THOMAS [REDACTED] LOMBARDOS</b>		<b>SEPT 24, 1966 7<sup>55</sup> P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL Hospital</b>		A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 12-05</b> D. STREET ADDRESS (If rural, give location) <b>1808 ST. PAUL ST.</b>	
5. SEX <b>M</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>DIVORCED</b>	8. DATE OF BIRTH <b>12-03-21</b>
9. AGE (In years last birthday) <b>44</b>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>TURKEY</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Dimitri Lombardo</b>	
14. MOTHER'S MAIDEN NAME <b>SULTANA</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>218-32-9502</b>		17. INFORMANT ADDRESS <b>DIVORCED WIFE - 1612 S. HANOVER ST. + PASSPORT</b>	
18. <b>330X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Intoxicant + subarachnoid hemorrhage</b> DUE TO (B) <b>probably due to</b> DUE TO (C) <b>ruptured cerebral aneurysm.</b>	
INTERVAL BETWEEN ONSET AND DEATH		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION <b>10</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>SEPT 23 1966</b> to <b>SEPT 24 1966</b> , that (I) (we) last saw the deceased alive on <b>SEPT 24 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Wina Rawlings</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>NINA RAWLINGS</b>		23D. ADDRESS <b>MARYLAND GENERAL Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9/27/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>St. Carmel Cem</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. [REDACTED]</b>	
25C. FUNERAL DIRECTOR <b>Joseph J. Zannone Jr.</b>		ADDRESS <b>763 S. Conkling St.</b>	



RECEIVED

1808

1808

RECEIVED GENERAL 1808

M WHITE DIVORCED 1808

1808

COOK

Dimari Lombardo

OUTTAWA

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09781		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09781	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		FLOHR, JOHN BENJAMINE		2. DATE AND HOUR OF DEATH 9-26-66 11:52 A.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY		MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 21228	
ST AGN ES HOSPITAL		D. STREET ADDRESS (If rural, give location)		15 MAGRUDER AVE. 21228	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-5-01	9. AGE (In years lost birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME JOHN		14. MOTHER'S MAIDEN NAME LILLIE C. ARMSTRONG	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN NO		16. SOCIAL SECURITY NO. 215-10-6778		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Myocardial Infarct (B) DUE TO Coronary Artery Heart (C) DUE TO Hypertension & CHF		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 28 1966 to SEPTEMBER 26 1966, that (I) (we) last saw the deceased alive on SEPTEMBER 26 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Jimenez		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/26/66	
23C. PHYSICIAN'S NAME (Type) M. JIMINEZ		23D. ADDRESS ST. AGNES HOSPITAL; CATON & WILKENS AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) ENTOMBMENT		24B. DATE 9/29/66		24C. NAME OF CEMETERY or CREMATORY LORRAINE	
24D. LOCATION (City, town, or county) (State) BALTO. CO.		25A. DATE REC'D BY HEALTH DEPT. SEP 29 1966			
25B. NAME OF REGISTRAR R. B. E. Finkbeiner		25C. FUNERAL DIRECTOR E. S. MALNABD			
25D. ADDRESS 301 FREDERICK RD		25E. CITY, STATE, ZIP 21228			

21229

LIARIE C. WILKINSON

ALL-STATE LIFE INSURANCE CO.

NO

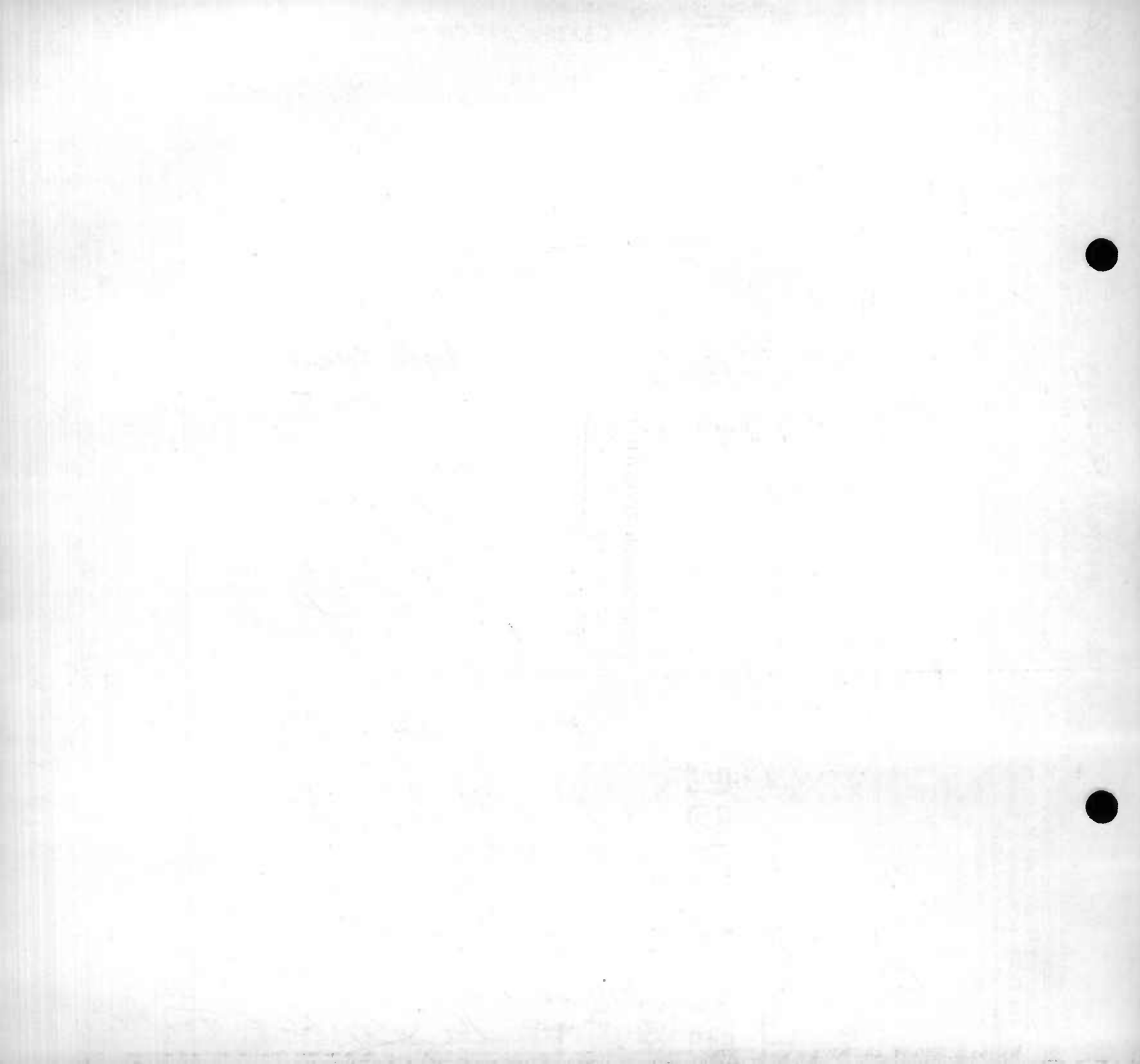
Estimate - People's Service

State Co. Insurance Co.  
21229

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

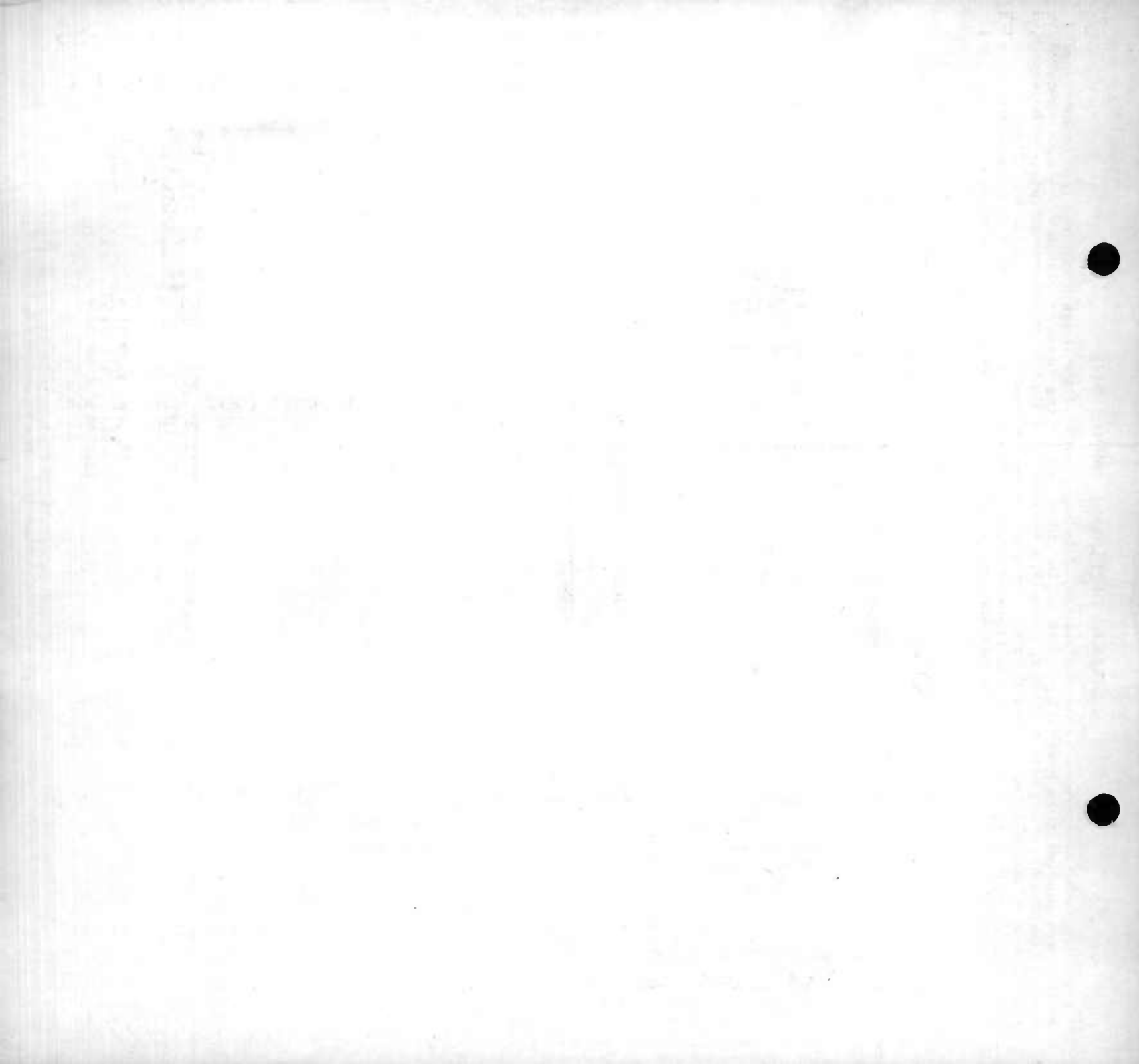
BIRTH NO. 66 09782				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09782	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>NETTIE M. NELSON</b>				2. DATE AND HOUR OF DEATH <b>Sept. 27, 1966 9:30 P.M.</b>			
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 South Baltimore General Hospital</b>		(If not in hospital or institution give street address or location)		A. STATE <b>MARYLAND</b>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		<b>23-03</b>	
				D. STREET ADDRESS (If rural, give location) <b>1834 Light St.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b>		8. DATE OF BIRTH <b>7-28-78</b>	9. AGE (in years last birthday) <b>88</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph MEYERS</b>				14. MOTHER'S MAIDEN NAME <b>Angela Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>AUDREY LUTZ -</b>		ADDRESS <b>1834 Light St. Baltimore, Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>420.04-2903.0</b>				CAUSE OF DEATH <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>Fracture Femur</b>			
19A. DATE OF OPERATION <b>9/10/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fracture, Neck of Femur Rt</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>23-03</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HOME</b>		21C. WHERE DID INJURY OCCUR? <b>1834 Light St. Baltimore, Md.</b>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>Sept. 9, 1966 6AM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Patient slipped &amp; fell on the floor</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 8, 1966</b> to <b>Sept. 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept. 27, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Gonzalo Guacena Jr.</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/27/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>GONZALO GUACENA, JR.</b>		23D. ADDRESS M.D. <b>South Baltimore Gen. Hospital</b>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>D</b>		24B. DATE <b>10-1-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven</b>		24D. LOCATION (City, town, or county) (State) <b>Baets, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>McCally 130 E Fell Ave.</b>		ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09783	
BIRTH NO. 66 09783		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) STEINHART - Hennie		2. DATE AND HOUR OF DEATH 230 AM 9/27/66	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital		C. CITY OR TOWN (If outside city limits, write R.U.R. and give township) Baltimore 15-09		D. STREET ADDRESS (If rural, give location) 3902 FAIRFAX RD	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 3-22-86	9. AGE (In years lost birthday) 80	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE - Retired		10B. KIND OF BUSINESS OR INDUSTRY Sinai Hospital		11. BIRTHPLACE (State or foreign country) Baltimore MD	
13. FATHER'S NAME Leopold Steinhart		14. MOTHER'S MAIDEN NAME Frances		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Miss Hennie Steinhart (Self) same address	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Myelofibrosis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		II Diabetes Mellitus	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/26 1966 to 9/27 1966, that (I) (we) lost saw the deceased alive on 9/27 1966 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Anthony Bottone M.D.				23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/29/1966		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 29 1966		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR Wm. J. Johnson		25D. ADDRESS 1217 North 1st Ave.			



FUNERAL DIRECTOR: IMPORTANT

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<p>W-412</p> <p>BIRTH NO. <span style="font-size: 1.5em;">66 09784</span></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">Registered No. <span style="font-size: 1.5em;">66 09784</span></p>			
<p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Elsie Williams</span> <span style="font-size: 1.5em; margin-left: 20px;">(Elsie)</span></p>		<p>2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">9-26-66</span> <span style="float: right; font-size: 1.2em;">3:35a.m.</span></p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">Provident Hospital 1514 Division Street Baltimore, Maryland</span></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Chase, Md.</span></p> <p>D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">Route #14 Box 371</span></p>	
<p>5. SEX <span style="font-size: 1.2em;">Female</span></p>	<p>6. RACE <span style="font-size: 1.2em;">Negro</span></p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Married</span></p>	<p>8. DATE OF BIRTH <span style="font-size: 1.2em;">12-12-13</span></p>
<p>9. AGE (In years last birthday) <span style="font-size: 1.2em;">53 yrs.</span></p>		<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">House wife</span></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME <span style="font-size: 1.2em;">Carroll W. Johnson</span></p>		<p>14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Laura Lins</span></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">220-207094</span></p>	
<p>17. INFORMANT <span style="font-size: 1.2em;">Howard M. Williams</span></p>		<p>ADDRESS <span style="font-size: 1.2em;">Same</span></p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Cerebral Vascular Accident</span></p>		<p>INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">2 hours</span></p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) <span style="font-size: 1.2em;">Essential Hypertension</span></p> <p>(C)</p>	
<p>II</p>			
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="font-size: 1.2em;">Diabetes Mellitus</span></p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">September 26, 19 66</span> to <span style="font-size: 1.2em;">September 26, 19 66</span>, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">September 26, 19 66</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <span style="font-size: 1.2em;">Gilbert L. Banfield</span></p>		<p>23B. DATE SIGNED <span style="font-size: 1.2em;">9-26-66</span></p>	
<p>23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Gilbert L. Banfield, M.D.</span></p>		<p>23D. ADDRESS <span style="font-size: 1.2em;">722 N. Fulton Avenue Balto., Maryland</span></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span></p>		<p>24B. DATE <span style="font-size: 1.2em;">9/29/66</span></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Sharp S. Methodist Chase</span></p>		<p>24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Md.</span></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">SEP 29 1966</span></p>		<p>25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Johnson</span></p>	
<p>25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">William H. Phillips</span></p>		<p>ADDRESS <span style="font-size: 1.2em;">1727 M. Wood</span></p>	

1914 Division Street  
Baltimore, Maryland

Chas. C. ...

1914 Division Street

1914 Division Street

1914 Division Street

*[Faint, illegible handwriting]*

1914 Division Street

1914 Division Street

1914 Division Street

1914 Division Street

September 20, 1914  
September 20, 1914

1914

2

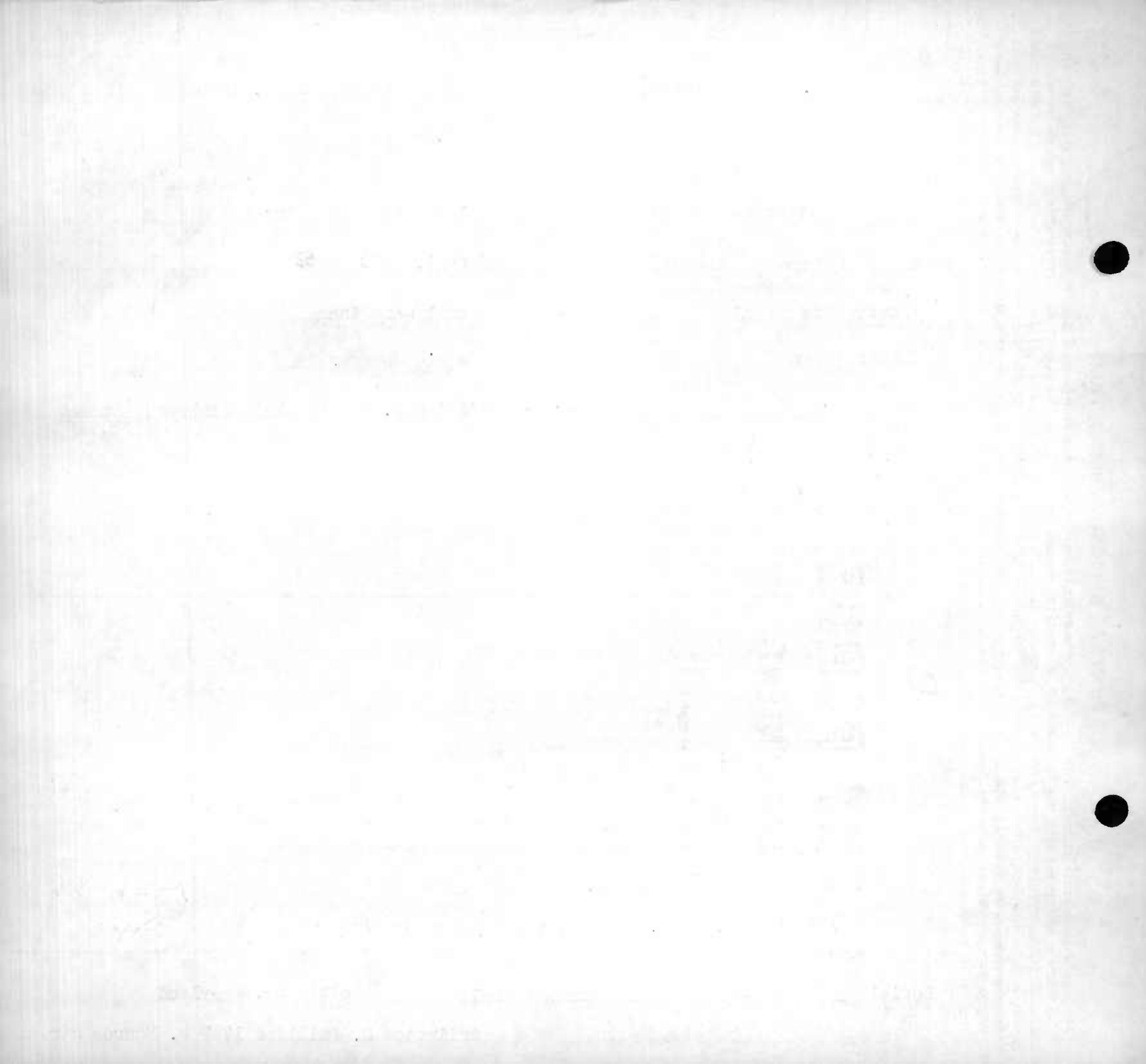
1914 Division Street



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 09785		CERTIFICATE OF DEATH		Registered No. 66 09785	
1. NAME OF DECEASED (Type or Print) <b>Eva D. Crosby (Oeva)</b>						2. DATE AND HOUR OF DEATH <b>September 23, 1966</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>46 Lutheran Hospital Baltimore, Maryland</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>15-02</b> D. STREET ADDRESS (If rural, give location) <b>1631 Ashburton Street</b>			
5. SEX <b>Female</b>		6. RACE <b>Colored</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>June 1, 1913</b>		9. AGE (In years last birthday) <b>53</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Thomas Awson</b>						14. MOTHER'S MAIDEN NAME <b>Carrie Johnson</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-32-4526</b>		17. INFORMANT <b>William D. Crosby</b> ADDRESS <b>1631 Ashburton Street</b>			
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) <b>explanatory occlusion</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
						(B) _____ DUE TO			
				(C) _____ DUE TO					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 12 1966</b> to <b>Sept 22 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 22 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
23A. SIGNATURE <b>William H. Wath</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED <b>9-26-66</b>			
23C. PHYSICIAN'S NAME (Type) <b>William H. Wath</b> M.D.						23D. ADDRESS <b>515 N. Arlington Ave</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-27-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1966</b>		25B. NAME OF REGISTRAR <b>R. E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Arlington S. Phillips</b>		ADDRESS <b>1727 N. Monroe Street</b>			



66 09786

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09786

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES W. MILLARD

2. DATE AND HOUR PRONOUNCED DEAD

September 25, 1966 11:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2926 Cherry Land Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2926 Cherry Land Road

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 30, 1890

9. AGE (In years  
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Edward Millard

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. (If yes, give war or dates of service))16. SOCIAL  
SECURITY NO.

218-09-4349

17. INFORMANT

ADDRESS

Frances Millard Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Carcinoma of stomach  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 26, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9/29/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery

23D. LOCATION

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 29 1966

24B. NAME OF REGISTRAR

R. E. E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Wilmington S. Phillips 1727 N. Market St.

ADDRESS

WATKINS POLICE

NOTAL BY MISS S. CHERRY OF WATKINS

Handwritten notes, possibly a signature or date, including "1929" and "March 1929".

WATKINS POLICE

G-635 66 09787

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09787

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JIM D. GORDON

2. DATE AND HOUR PRONOUNCED DEAD

September 23, 1966 6:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Mercy Hospital

DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

732 E. Preston Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Never married

8. DATE OF BIRTH

May 8, 1937

9. AGE (In years  
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Bracey Va.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Willie J. Gordon

14. MOTHER'S MAIDEN NAME

Mary Jane Bennett

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

Oct 3, 1950 to Sept 24, 1952

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mr. Roscoe Bennett 732 E. Preston St.  
Baltimore, Md.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Asphyxia by carbon monoxide, during  
acute ethylism

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic heart disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

3rd Floor Rear 732 E. Preston Street

21D. TIME  
OF INJURY  
(APPROX.) 9-23-66 6:15 A

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Fire in subjects room

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

September 23, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Sept. 30, 1966

23C. NAME OF CEMETERY or CREMATORY

Rosa Lee Brown  
Baptist Cemetery

23D. LOCATION

Bracey, Va

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 29 1966

24B. NAME OF REGISTRAR

P. C. E. Jackson

24C. FUNERAL DIRECTOR

Elmer E. Bullock

ADDRESS

712-14 E. North Ave  
Baltimore, Maryland

ALL CONTENT

WALLLEY FIDINGIT



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09788	
BIRTH NO. 66 09788				MORTUARY SERVICE - BCHD	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) B/G of Lousie Averette				Sept. 28, 1966 4:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
The Johns Hopkins Hospital				Maryland 21231	
5. SEX Female				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
6. RACE Negro				Baltimore	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEW BORN				D. STREET ADDRESS (If rural, give location)	
8. DATE OF BIRTH 9/11/66				1230 E. Federal Street	
9. AGE (In years last birthday)				If Under 1 Yr. Months 17 If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Ozon				Louise	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
17. INFORMANT				ADDRESS	
18. 774X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO Septicemia	
ANTECEDENT CAUSES				(B) DUE TO Deficient Immune System	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Low Birth Weight (610 gms)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Interval Between Onset and Death	
19A. DATE OF OPERATION				20A. AUTOPSY? (Yes or No) Yes	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?				21G. WHERE DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/28/66 to 9/28/66				22. I certify that (I) (we) lost saw the deceased alive on 9/28/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE H. Swick				23B. DATE SIGNED 9/28/66	
23C. PHYSICIAN'S NAME (Type) H. Swick				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation				24B. DATE 9/28/66	
24C. NAME of CEMETERY or CREMATORY The Johns Hopkins Hospital				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1966				25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR				25D. ADDRESS	

11/13



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09789		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09789	
M.E. CASE NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Charles A. Kitzman		2. DATE AND HOUR OF DEATH 26 Sept. 1966 12:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 4940 Eastern Avenue Baltimore City Hospitals Baltimore, Maryland #21224		A. STATE Maryland		B. COUNTY Baltimore	
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, SEPARATED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY CHESTER, PA. FIRE DEPT		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
13. FATHER'S NAME AUGUST KITZMAN		14. MOTHER'S MAIDEN NAME Augustine SCHNITZER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 194-20-8986		17. INFORMANT ADDRESS #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Cordiac Arrest CHF		INTERVAL BETWEEN ONSET AND DEATH 2 mo	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes mellitus, regular		2 months	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if this hospital) attended the deceased from 20 Sept 1966 to 26 Sept 1966, that (we) last saw the deceased alive on 20 Sept 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did not) view the body after death.					
23A. SIGNATURE D A Rain Jr		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 26 Sept 1966	
23C. PHYSICIAN'S NAME (Type) Dr. D. A. Rain, Jr.		23D. ADDRESS M.D. BCH-4940 Eastern Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-28-66		24C. NAME OF CEMETERY or CREMATORY FIRST UN. EVANGELICAL CEM	
24D. LOCATION 6115 O'DONNELL ST. BALTO., 24, MD		24E. DATE REC'D BY HEALTH DEPT. SEP 29 1966		24F. NAME OF REGISTRAR Robert E. Farkner	
24G. FUNERAL DIRECTOR Charles S. Feiler		24H. ADDRESS 901 S. CONKLEIN ST. BALTO., 24, MD.			

Charles A. Kitzman 30 Sept 1934

W. W. 8/17/01 22  
Belmont City Hospital  
Belmont  
Merrill

Charles  
Hagston

Charles H. Hest

CHF

Charles H. Hest, Jr.

30 Sept 1934

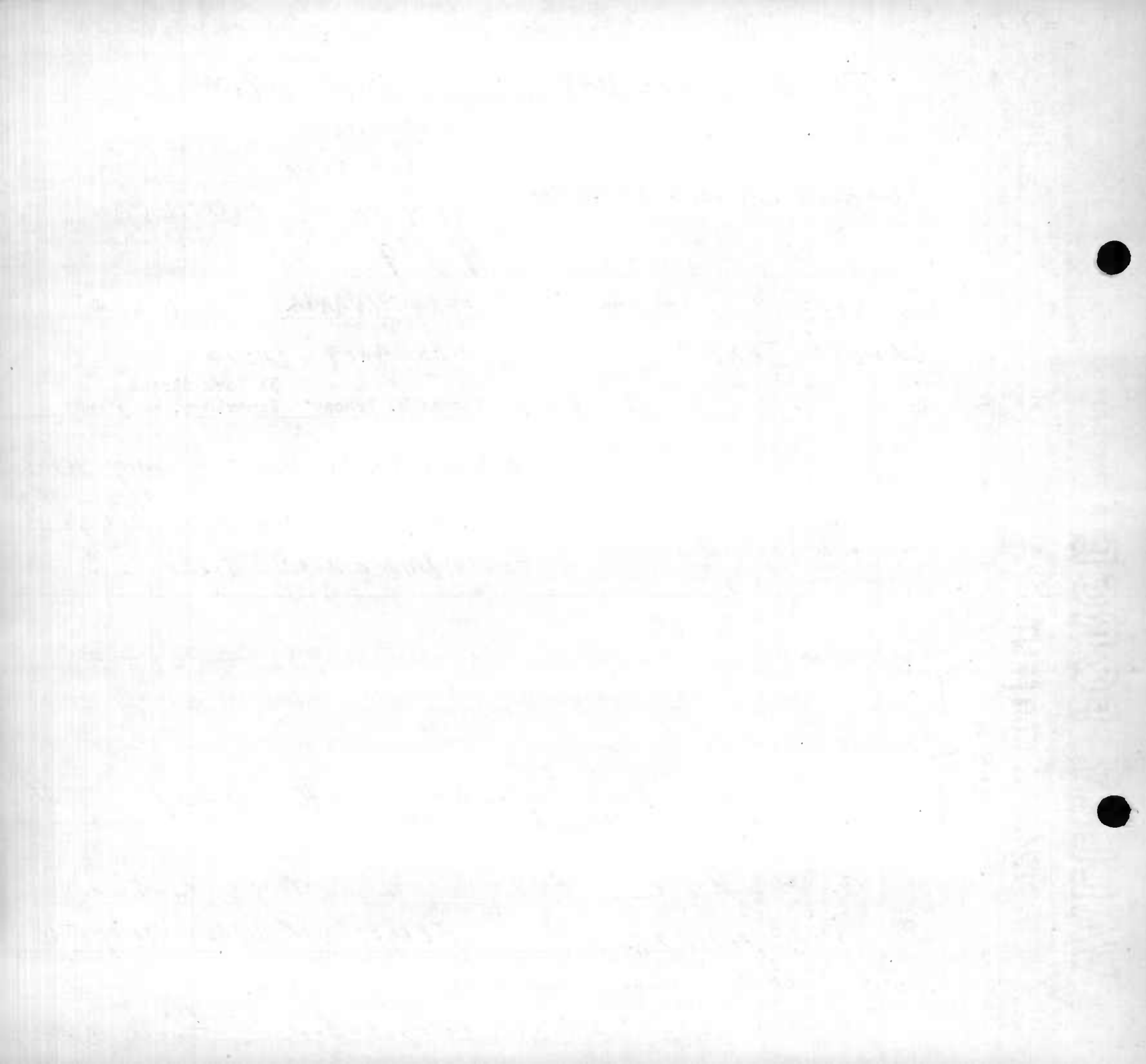
Belmont

30 Sept 1934

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

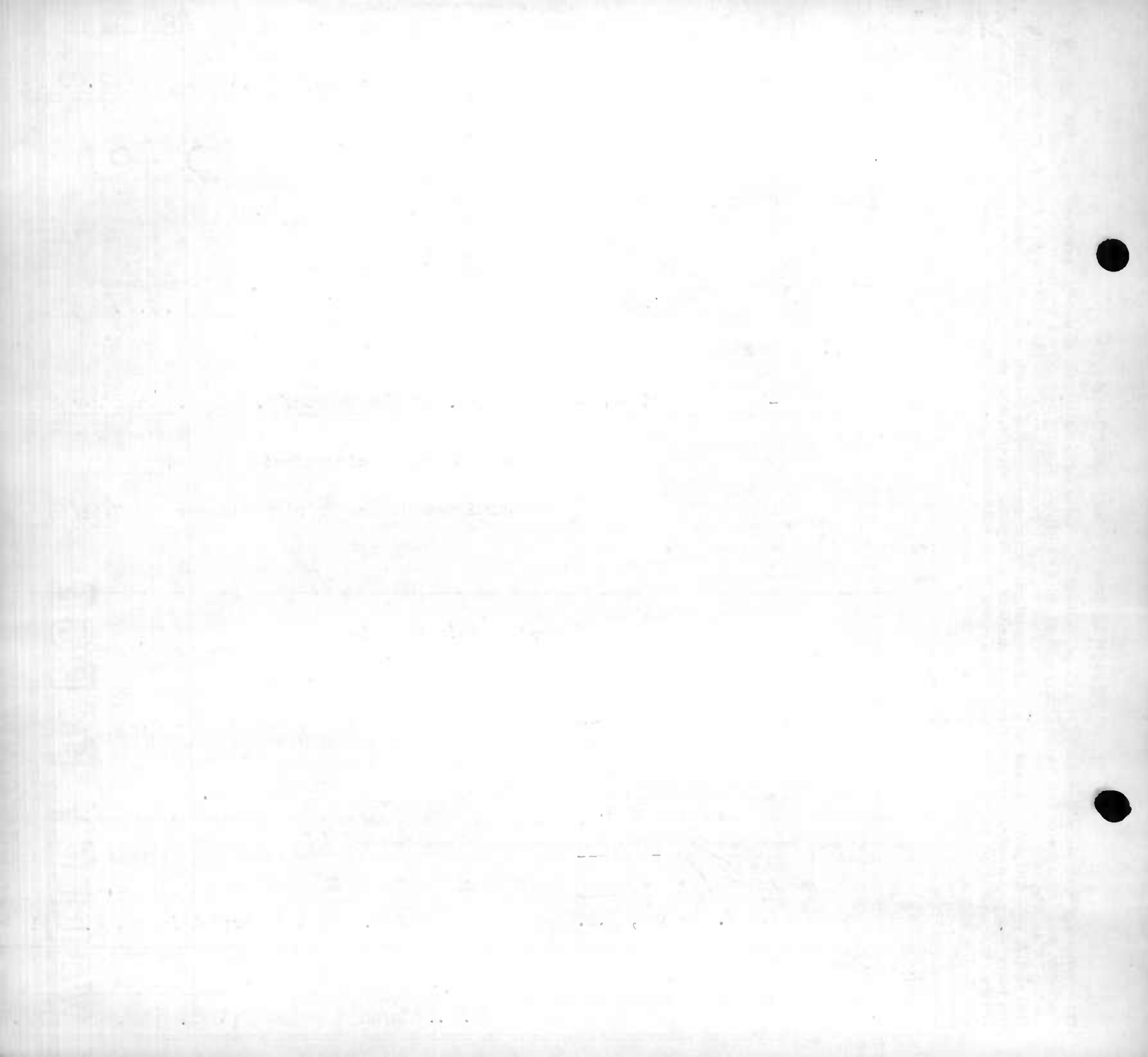
BIRTH NO. 66 09790		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09790	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) TRACEY, ETHEL MAY			Sept. 27, 1966		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL			A. STATE MARYLAND B. COUNTY		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) TANEY TOWN 56-00		
			D. STREET ADDRESS (If rural, give location) 31 YORK ST. CARROLL CO.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6/3/1899	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME SAMUEL JONES			14. MOTHER'S MAIDEN NAME MARGARET DAVIS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) No		16. SOCIAL SECURITY NO. 220 283136	17. INFORMANT Thomas H. Tracey		
			ADDRESS 31 York Street Taneytown, Maryland		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH many years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Congestive Heart Failure			DUE TO 9/23 - 9/27		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute Myocardial Infarction, ?					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-23-1966 to 9-27-1966, that (I) (we) lost saw the deceased olive on 9-27-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. H. Lee			23B. DATE SIGNED Sept. 27		
23C. PHYSICIAN'S NAME (Type) CHULLAH, LEE			23D. ADDRESS FRANKLIN SQUARE HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/30/66		24C. NAME OF CEMETERY or CREMATORY Grace Reformed Cemetery	
				24D. LOCATION (City, town, or county) (State) Taneytown, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1966		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR John M. Skelton C.O. FUSSELL & SON TANEYTOWN, MD.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">66 09791</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 1.5em;">66 09791</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">ALLE MESTAFE</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">September 27, 1966</span>   <span style="font-size: 1.2em;">2.00 P.M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <span style="font-size: 1.2em;">232 S. Chester Street</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">2-01</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">232 S. Chester Street</span>		
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">3/25/1892</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">74</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">House Painter</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Self-employed</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Turkey</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">?? Mestafe</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Unknown</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-16-4976</span>			17. INFORMANT <span style="font-size: 1.2em;">Mrs. Nannie Mestafe, 232 S. Chester St</span>		
18. I <span style="font-size: 1.2em;">187.0</span> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="font-size: 1.2em;">Osteo-Arthritis of Spine</span>			CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Metastatic Carcinomatosis</span> DUE TO (B) <span style="font-size: 1.2em;">Carcinoma of the Urinary Bladder</span> DUE TO (C)  INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">7/31/65</span>		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">July 31</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">Sept. 27</span> 19 <span style="font-size: 1.2em;">66</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Sept. 27</span> 19 <span style="font-size: 1.2em;">66</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Joseph F. Drenda</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">Sept. 28, 1966</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Joseph F. Drenda, M.D.</span>			23D. ADDRESS <span style="font-size: 1.2em;">209 S. Chester Str, Baltimore, Md. 21231</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">9/30/66</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Oak Lawn</span>	
24D. LOCATION <span style="font-size: 1.2em;">Baltimore, Maryland</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">SEP 20 1966</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">R. E. Taylor</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">M. F. SADOWSKI &amp; SONS, 1808 EASTERN AVE.</span>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09792				BALTIMORE CITY HEALTH DEPT.		Registered No. 66 09792	
M.E. CASE NO.				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <b>MC KENZIE, JOHN</b>				2. DATE AND HOUR OF DEATH <b>9-26-66 11 20 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVE BALTIMORE, MD #21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1119 ARGYLE AVE #21201</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWER</b>	8. DATE OF BIRTH <b>8-13-82</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>TAYLOR MCKENZIE</b>				
14. MOTHER'S MAIDEN NAME <b>ELSIE JONES</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				
16. SOCIAL SECURITY NO. <b>215-16-0820</b>			17. INFORMANT <b>BALTIMORE CITY HOSPITALS</b> ADDRESS <b>RECORDS: 4940 EASTERN AVE. BALTO., MD. #21224</b>				
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>ASCVD - sev. - with CNS involm DUE TO INCLUDING BRAIN STEM</b> ANTECEDENT CAUSES <b>CHRONIC Pyelonephritis</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>? RECURRENT Pulmonary Emboli</b>				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>URINARY TRACT INF.</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTAINING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/29</b> 19 <b>66</b> to <b>9/26</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/26</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Richard Maffezzoli</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/26/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MAFFEZZOLI, RICHARD D.</b>				M.D. <b>BALTIMORE CITY HOSPITALS - Md.</b>		23D. ADDRESS <b>4940 EASTERN AVENUE #21224 BALTO.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-29-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>SEP 29 1966</b>		25C. FUNERAL DIRECTOR <b>Francis A. Hemley</b>		578 W. Biddle st	

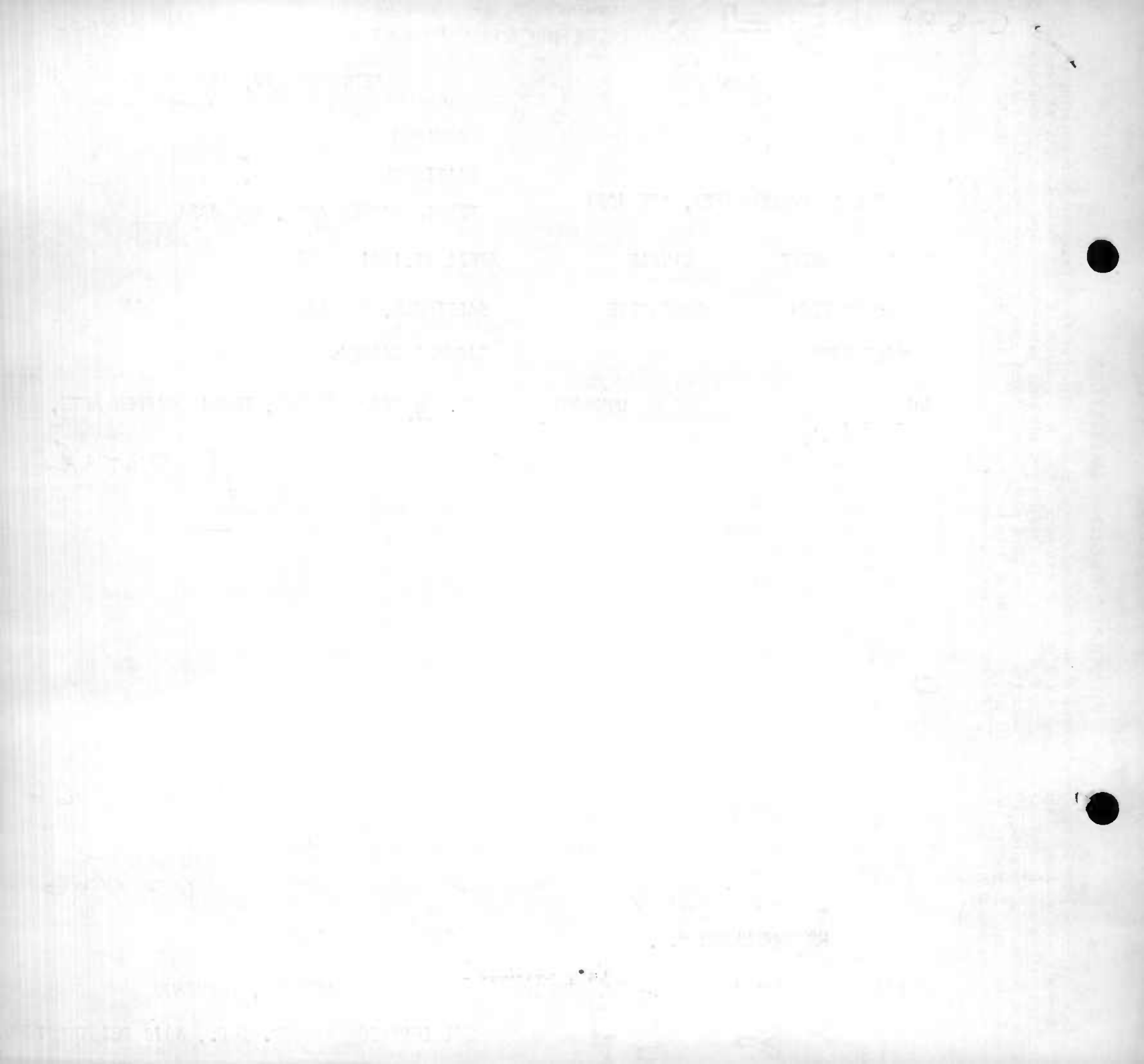




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

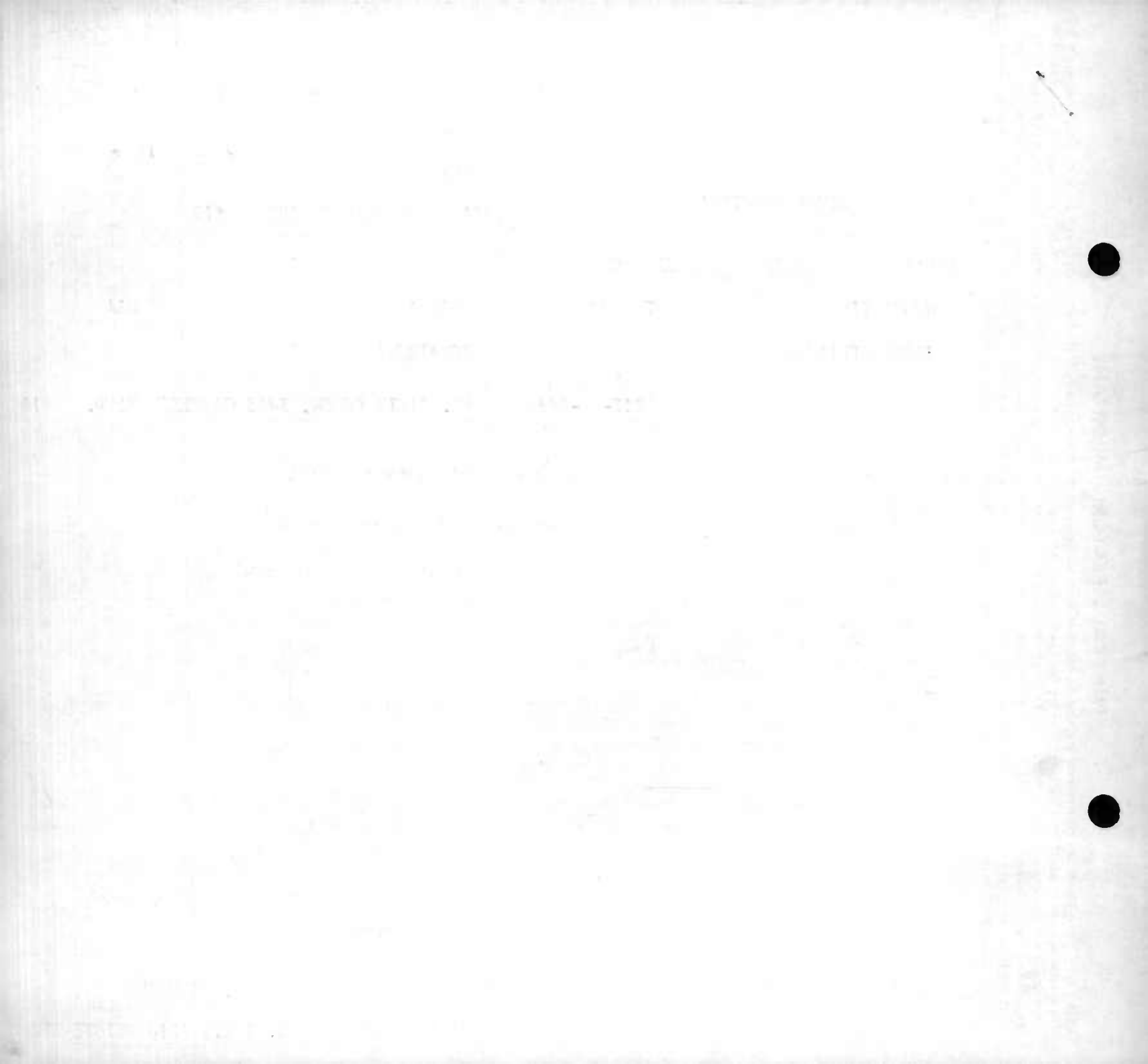
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09793</u>	
BIRTH NO. <u>66 09793</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>LENA COHN</u>		2. DATE AND HOUR OF DEATH <u>SEPTEMBER 27, 1966</u> <u>2:10</u> P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <u>TEMPLE GARDEN APTS, APT 403A</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>TEMPLE GARDEN APTS, APT 403A</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>APRIL 17, 1901</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CORPORATION</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>EXECUTIVE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>WOLF COHN</u>		14. MOTHER'S MAIDEN NAME <u>RACHAEL SAFFRAN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MR. CHARLES GORFINE, TEMPLE GARDEN APTS, APT 907</u>	
18. <u>331 XI</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Hemorrhage</u> <u>Arteriosclerosis</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>9/27</u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>9/26</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>2</u>					
23A. SIGNATURE <u>M.S. Shiling</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>9/27/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>M.S. SHILING</u>		23D. ADDRESS <u>2500 EUTAW PLACE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9/28/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>UNITED HEBREW</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>SOL LEVINSON</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. <u>66 09794</u>	
BIRTH NO. <u>66 09794</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>DOROTHY COHEN</u>		2. DATE AND HOUR OF DEATH <u>9/28/66</u> <u>16<sup>15</sup></u> A.M.	
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL</u>		D. STREET ADDRESS (If rural, give location) <u>4316 PARK HEIGHTS AVENUE #15</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>66</u>	9. AGE (In years lost birthday) <u>66</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JACOB STELMACH</u>		14. MOTHER'S MAIDEN NAME <u>SCHAINDEL ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-20-3033</u>		17. INFORMANT <u>MR. ALVIN COHEN, 3403 GARRISON BLVD. #15</u>	
18. <u>416X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>CEREBRAL THROMBOSIS</u> DUE TO <u>ATRIAL FIBRILLATION</u> DUE TO <u>RHEUMATIC HT. DISEASE</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/26</u> <u>1966</u> to <u>9/28</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>9/28</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James Sobel</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/28/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>JAMES SOBEL</u>		23D. ADDRESS M.D. <u>SINAI HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9/28/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>HEBREW YOUNG MENS</u>	
24D. LOCATION <u>BALTIMORE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</u>	



BIRTH NO.		M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
66 09795		C-250		JOSEPH CHASEN		September 27, 1966		10:35 P.M.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE				B. COUNTY	
Union Memorial Hospital				Maryland					
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)					
				Baltimore				27-16 AVE.	
				D. STREET ADDRESS (If rural, give location)				3422 ST. AMBROSE	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White		MARRIED		MARCH 14, 1914		52	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
CHAUFFEUR		TAXI CAB		BALTIMORE, MARYLAND		USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
ABRAHAM CHASEN				ETHEL ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO				UNKNOWN		MRS. MARY CHASEN, 3422 ST. AMBROSE AVENUE #1			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
443X I				Arteriosclerotic and Hypertensive Cardiovascular Disease					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO					
				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				Yes		Yes			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from:				Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
Rudiger Breiteneker				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				9/28/66	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>									
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)			
BURIAL		102/66		HAR ZION TIFERETH ISRAEL		BALTIMORE, MARYLAND			
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		24D. ADDRESS			
SEP 29 1966		Robert E. Taylor		SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN					

0000 0000 0000 0000

# FUNERAL DIRECTOR: IMPORTANT

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47-25-19 DH				BALTIMORE CITY HEALTH DEPARTMENT		Register No. 66 09796	
BIRTH NO. 66 09796				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Edna Mae Cole</u>				2. DATE AND HOUR OF DEATH <u>9-27-66</u> <u>5:35 PM</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND #21224</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>10-2</u> D. STREET ADDRESS (If rural, give location) <u>703 Sterling St #21202</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SEPARATED</u>		8. DATE OF BIRTH <u>12-10-20</u>	9. AGE (In years lost birthday) <u>(46) 45</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MD MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward WELLS</u>				14. MOTHER'S MAIDEN NAME <u>Leona HENSON</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>RECORDS: BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MD. #21224</u>	
18. I <u>171X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Carcinoma of the Cervix</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9-27-66</u> 19 to <u>9-27-66</u> 19, that (I) (we) last saw the deceased alive on <u>9-27-66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>William A. Emerson</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <u>9-27-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>WILLIAM A. EMERSON</u>				23D. ADDRESS <u>4940 EASTERN AVE. BALTIMORE, MD.</u> <u>Baltimore City Hospital #21224</u>			
24A. BURIAL CREMATION, REMOVAL (specify)		24B. DATE <u>10/1/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Howell Road Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u>		25C. FUNERAL DIRECTOR <u>Donald P. Glover</u>		ADDRESS <u>7019 Patterson St.</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09797				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09797	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Burth Kelly (Kelly)</i>				2. DATE AND HOUR OF DEATH <i>September 25, 1966</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>SINAI HOSPITAL</i>				A. STATE <i>Md</i> B. COUNTY <i>Bald</i>			
C. CITY OR TOWN (If outside city limits, give RURAL and give township) <i>Bald</i>				D. STREET ADDRESS (If rural, give location) <i>Bar-Wil-Bar Conv. Home</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>3-25-1897</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>UNKNOWN</i>			14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>M. E. Elickson</i>		ADDRESS <i>1129 N. CAROLINE</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>422.1 I Arteriosclerotic C.V.D.</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8-30-66</i> 19 to <i>9-24-</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9-24-</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>C.R. Campbell</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>9-27-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>C.R. Campbell</i>				23D. ADDRESS M.D. <i>1618 W. North Ave.</i>			
24A. BURIAL CREMATION REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>9/29/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT. CALVARY CEM</i>		24D. LOCATION (City, town, or county) (State) <i>A.A. COUNTY Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 29 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Milton E. Elickson</i>		ADDRESS <i>1129 N. CAROLINE</i>	



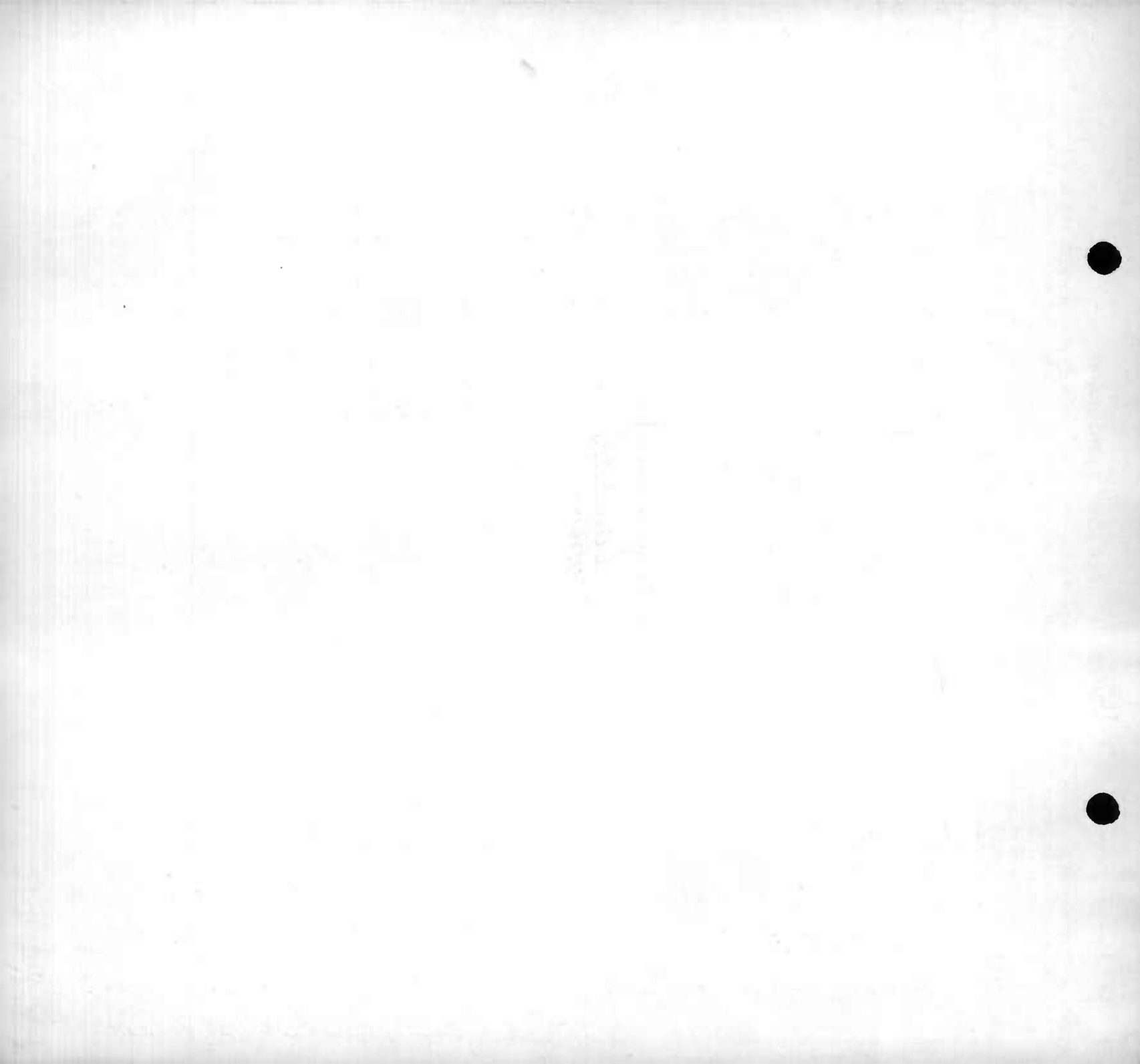
THE BODY OF WALLACE KNIGHT WAS RELEASED ON APPROVAL BY THE MEDICAL EXAMINER  
OFFICE BY DOCTOR BRIETENECKER

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09798		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09798	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Knight, Wallace</i>			2. DATE AND HOUR OF DEATH <i>9-27-66 8:30 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>			A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 8-04</i>		
			D. STREET ADDRESS (If rural, give location) <i>2204 HENNINGMAN AVE</i>		
5. SEX <i>M</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	B. DATE OF BIRTH <i>5-5-11</i>	9. AGE (In years last birthday) <i>55</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Beth Steel</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Beth Steel</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Charles</i>		14. MOTHER'S MAIDEN NAME <i>Thelma Knight</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Under</i>		16. SOCIAL SECURITY NO. <i>Under</i>		17. INFORMANT <i>Thelma Knight 2204 Henningman Ave</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Myocardial Infarction</i>		CAUSE OF DEATH (A) DUE TO <i>Hemorrhage</i> (B) DUE TO <i>Dissecting Aneurysm</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs</i> <i>11 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Died at operation for Aneurysm</i>			
19A. DATE OF OPERATION <i>9-27-66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Dissecting Aneurysm</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9-17-66</i> 19 <i>66</i> to <i>9-27</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Sept 27</i> , 19 <i>66</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Patrick E. Brookhouse</i> M.D.				23B. DATE SIGNED <i>Sept 27, 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>Patrick E. Brookhouse</i> M.D.				23D. ADDRESS <i>Johns Hopkins Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Sept 30/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Bald Hill Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>5501 Frederick Ave Baltimore</i>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>John T. Eubank</i>	
25C. FUNERAL DIRECTOR <i>John T. Eubank</i>		25D. ADDRESS <i>1129 N. Caroline St.</i>			

SEP 29 1966



66 09799

BALTIMORE CITY HEALTH DEPARTMENT

66 09799

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Gail Jefferson

2. DATE AND HOUR PRONOUNCED DEAD

9/26/66

6:01 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

200 N. Aisquith St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Oct 3, 1951

9. AGE (In years  
last birthday)

14

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Carl Jefferson

14. MOTHER'S MAIDEN NAME

Esther Coker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Esther Jefferson 200 N. Aisquith St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Massive internal bleeding  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Gunshot wound of chest, involving Liver,  
DUE TO both lungs and aorta

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

yard

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

rear of 401 N. Aisquith St.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
9 26 66 5:50 p.m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot in chest

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/27/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Sept 30/66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION

(City, town, or county)

Westport Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 29 1966

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

Milton E. Ellickson 1129 N. Caroline St

ADDRESS

WALLACE BOOK

1001

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09800		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09800	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) JAMES CAREY			2. DATE AND HOUR OF DEATH 9-26-66 3:20 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSP			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 14-03 D. STREET ADDRESS (If rural, give location) 2314 Division St		
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Wid	8. DATE OF BIRTH 11-29-21	9. AGE (In years last birthday) 44 yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME James Carey		
14. MOTHER'S MAIDEN NAME Julia Samuel			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 225-16-5600			17. INFORMANT ADDRESS Bobbie Carey 3614 Fariview Ave.		
18. I X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic renal Dis-uremia + salt Wasting			CAUSE OF DEATH (A) Hypertensive Encephalopathy (B) Malignant Hypertension (C) HTCV D		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 days 1 year
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-7-1966 to 9-26-1966, that (I) (we) last saw the deceased alive on 9-26-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. Portnoy			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-26-66
23C. PHYSICIAN'S NAME (Type) B. Portnoy			23D. ADDRESS UNIV. HOSP		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-1-66		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Pk/	
24D. LOCATION (City, town, or county) Arbutus, Maryland		(State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS GEORGE KELSON 1348 CALHOUN ST.	



JAMES C. CREE

4-22-66

E

UNIVERSITY HOSP

M C W

11-24-66

BALTIMORE  
3318 Division St

MD

Hypertensive Cardiopathy  
Malignant Hypertension  
HT 210

Chronic renal insufficiency  
YES

4-22

4-22

4-22

4-22

Chronic

UNIV HOSP



1  
P-625

66 09801

BALTIMORE CITY HEALTH DEPARTMENT

66 09801

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

James Pierson

2. DATE AND HOUR PRONOUNCED DEAD

9/27/66 11:10 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

720 Pierce St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

720 Pierce St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

7-12-93

9. AGE (In years  
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

215-07-2063

17. INFORMANT

ADDRESS

Alice Coleman 1103 Calhoun Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/27/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9-30-66

23C. NAME of CEMETERY or CREMATORY

Balto. National Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 29 1966

George Kelson 1348 N. Calhoun St.

# VALLEY FORDS

LOCAL CONTENT

1971-1972

1973-1974

1975-1976

1977-1978

1979-1980

1981-1982

1983-1984

1985-1986

1987-1988

1989-1990

1991-1992

1993-1994

1995-1996

1997-1998

1999-2000

2001-2002

2003-2004

2005-2006

2007-2008

2009-2010

1  
B-620

66 09802

BALTIMORE CITY HEALTH DEPARTMENT

66 09802

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Earl A. Brooks

2. DATE AND HOUR PRONOUNCED DEAD

9/27/66 8:30 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1423 Bruce St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1423 Bruce St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

7-6-25

9. AGE (In years  
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Richard Green

14. MOTHER'S MAIDEN NAME

Estelle Brooks

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

220-14-7608

17. INFORMANT

ADDRESS

Estelle Barney 1423 Bruce St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/27/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9-30-66

23C. NAME of CEMETERY or CREMATORY

Balto. Nat'l. Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore. Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

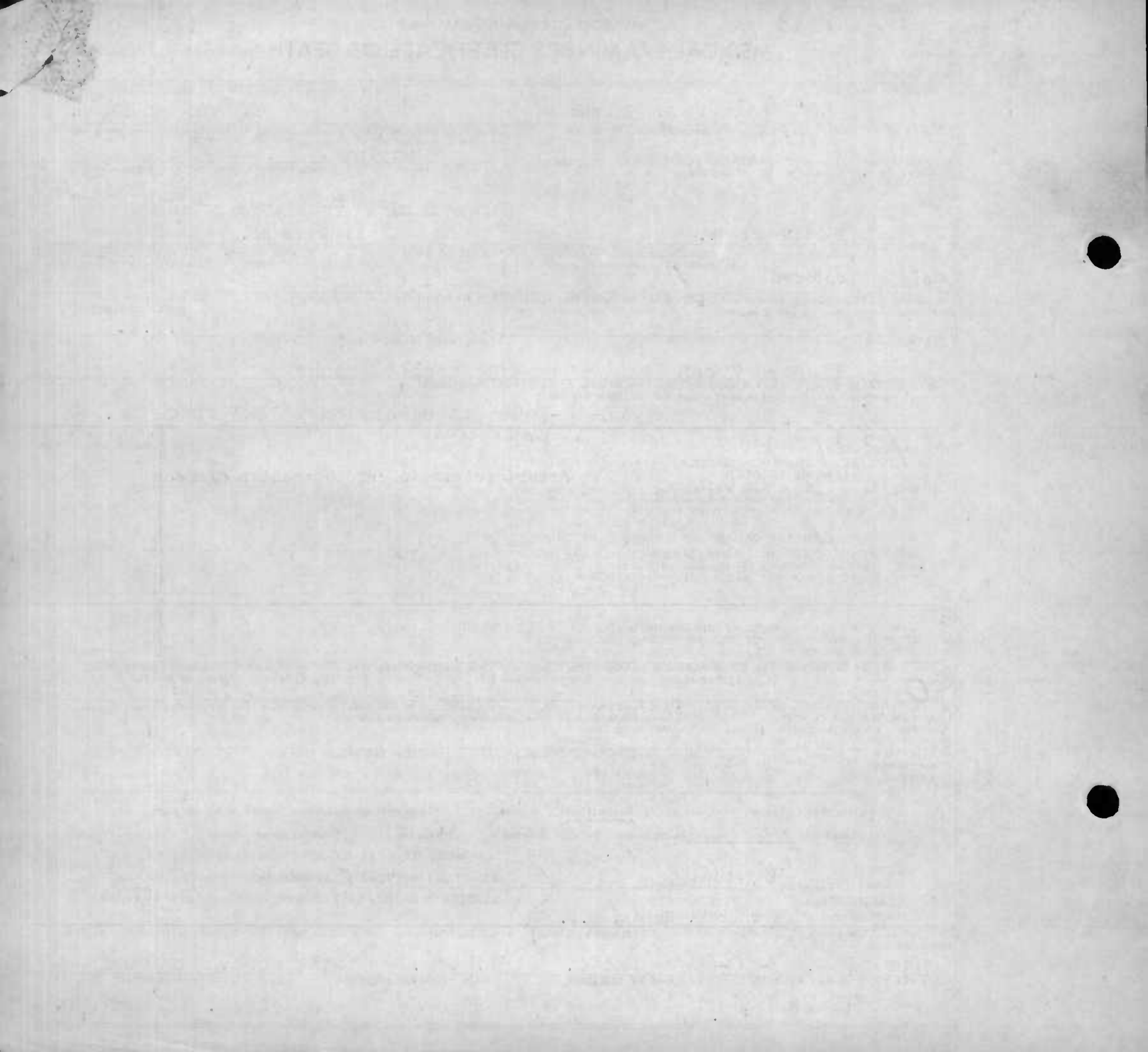
24C. FUNERAL DIRECTOR

ADDRESS

SEP 29 1966

Robert E. Taylor

George Kelson 1348 N. Calhoun St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09803</u>	
BIRTH NO. <u>66 09803</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Cora M. Wright</u>		2. DATE AND HOUR OF DEATH <u>9-26-66</u> <u>9 P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hospital</u>		A. STATE <u>Md.</u> B. COUNTY _____			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		D. STREET ADDRESS (If rural, give location) <u>1415 Hull St</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>m</u>	8. DATE OF BIRTH <u>3-3, 1908</u>	9. AGE (In years lost birthday) <u>58</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Maryland ?</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. _____		17. INFORMANT ADDRESS <u>Leon C. Wright 1415 Hull St.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>5-9-3X I</u>		CAUSE OF DEATH (A) <u>HYPERTENSION</u> DUE TO (B) <u>CHRONIC RENAL FAILURE</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH +</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (it) (this hospital) attended the deceased from <u>8/27</u> <u>1966</u> to <u>9/26</u> <u>1966</u> , that (it) (we) last saw the deceased alive on <u>9/26</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (It) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Coleman C. Heinritz</u>		M.D. _____		23B. DATE SIGNED <u>9/26/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Coleman C. Heinritz</u>		23D. ADDRESS <u>South Baltimore General Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/30/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill Cemetery Baltimore, Md.</u>	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>SEP 29 1966</u>		25C. FUNERAL DIRECTOR <u>Charles L. Stevens Funeral Home, Inc.</u> <u>1501 E. Fort Avenue</u>	

Contd. (continued)

8-3-1908

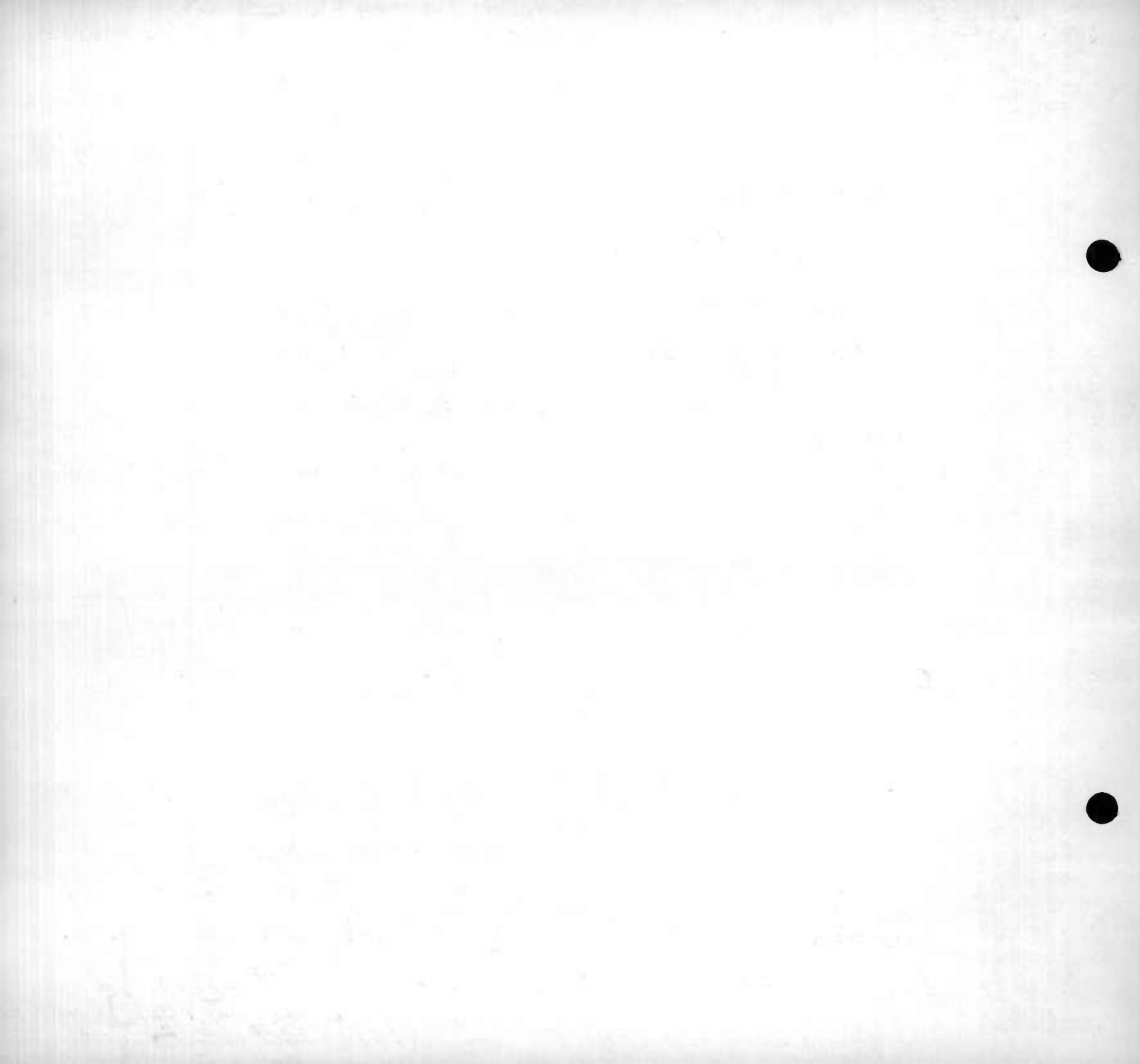
2nd General Hospital  
F W M  
8-3-1908 28  
Baltimore  
Md



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 09804</span>	
BIRTH NO. <span style="float: right;">66 09804</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>James Conrad F. Jennings</i>		2. DATE AND HOUR OF DEATH <i>9-22-66</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>1301 Andre ST.</i>		A. STATE <i>Maryland</i> B. COUNTY <i>24-01</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>1301 Andre ST.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>12/13/1907</i>	9. AGE (In years last birthday) <i>58</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>PT. Wilson Hospital</i>		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Franklyn Jennings</i>			
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes about 1924</i>			
16. SOCIAL SECURITY NO. <i>578-18-7240</i>		17. INFORMANT ADDRESS <i>Ruth Jennings 1301 Andre ST.</i>			
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <i>Coronary Occlusion Immediate</i> (B) <i>Coronary arteriosclerosis I-3 years</i> (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Pulmonary Tuberculosis (Arrested) ?</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/1 1963</i> to <i>9/22 1966</i> , that (I) (we) lost saw the deceased alive on <i>9/20 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Harry Deibel</i>				23B. DATE SIGNED <i>9/23/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Harry Deibel MD</i>				23D. ADDRESS <i>M.D. 1226 S Hanover Street Balto 21230, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/24/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 29 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor, MA</i>		25C. FUNERAL DIRECTOR <i>Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue</i>			

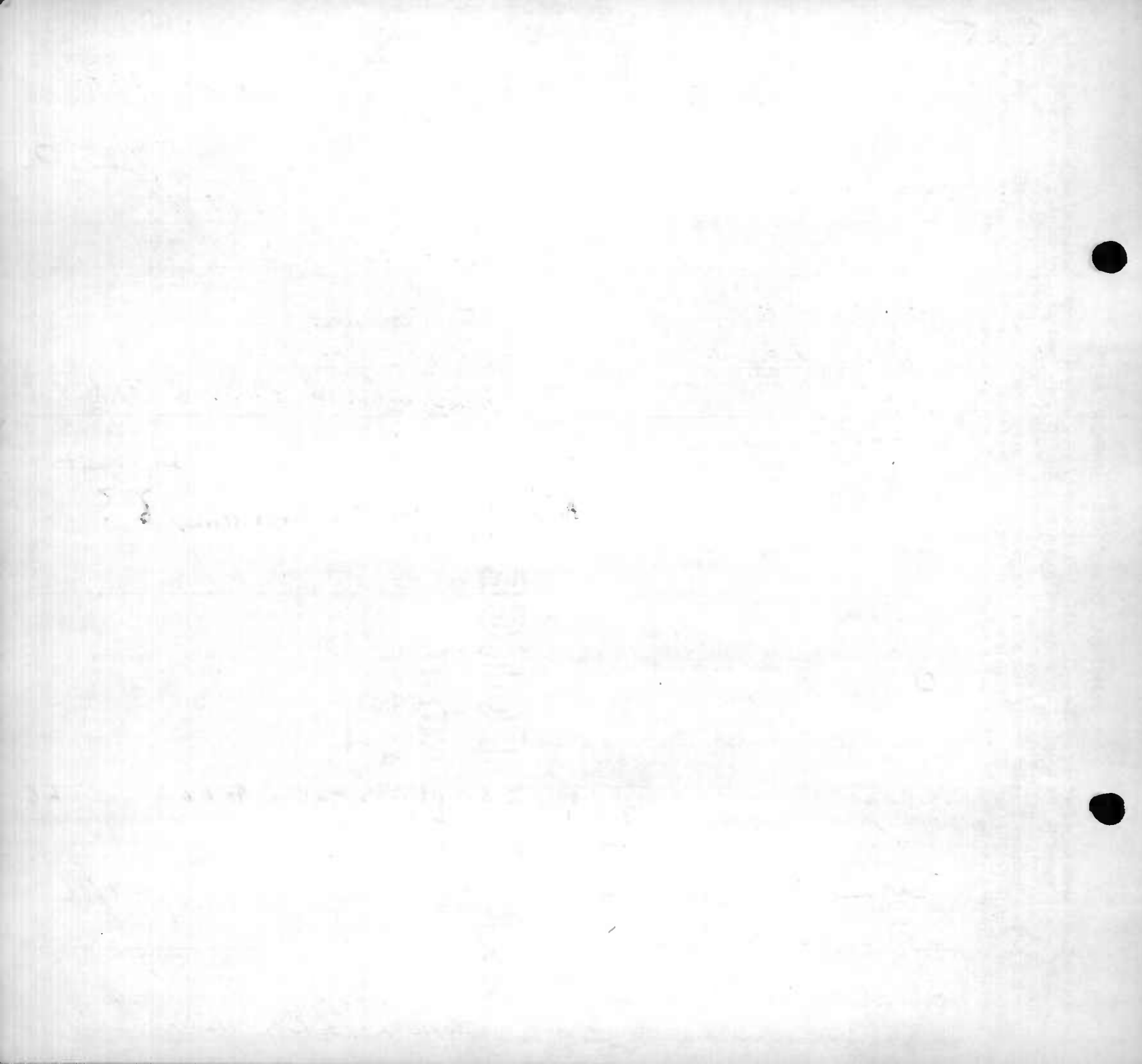




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09805</u>	
BIRTH NO. <u>66 09805</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>SARAH Johnson</u>		2. DATE AND HOUR OF DEATH <u>9/26/66</u> <u>10 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>John Hopkins Hosp.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>8-02</u>			
		D. STREET ADDRESS (If rural, give location) <u>2426 E. Federal St.</u>			
5. SEX <u>F.</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12/24/95</u>	9. AGE (In years lost birthday) <u>70</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRESSER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>	
13. FATHER'S NAME <u>JOE BRICE</u>		14. MOTHER'S MAIDEN NAME <u>FRANCIS Crawford</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>FIAMP. JOHNSON</u> ADDRESS <u>2426 E. Federal St.</u>	
18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>Cerebral Hemorrhage</u> (B) DUE TO <u>Arteriosclerotic Cerebrovascular Disease</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>September 1965</u> to <u>9-26-1966</u> , that (I) <u>we</u> last saw the deceased alive on <u>9-13-1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Eugene H. Owens</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>9/27/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Eugene H. Owens</u>		23D. ADDRESS <u>1735 E. Federal</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9/30/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Calvary</u>	
24D. LOCATION <u>A.A. County, Md</u>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Joseph H. Lock</u>		25C. FUNERAL DIRECTOR <u>1504 N. Central Ave</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09806		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09806	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) WILLIAM HARDESTY			2. DATE AND HOUR OF DEATH 9/28/66 7:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  48 Maryland General Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-06 D. STREET ADDRESS (If rural, give location) 2109 N. Charles St		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1/17/82	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	
13. FATHER'S NAME Tanjour Hardesty			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME Mary Jane Cornor		
16. SOCIAL SECURITY NO. 218-32-1705			17. INFORMANT E. <del>XXXX</del> McClure Rouzer 316 Equitable Bldg Baltimore, Md.		
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  CAUSE OF DEATH (A) Pneumonia (B) Anterior selected heart (C) Asphyxial pneumonia  INTERVAL BETWEEN ONSET AND DEATH  none					
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel E. Wilkerson			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-28-66
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS 421 Regester Ave		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/30/66		24C. NAME of CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION (City, town, or county) (State) Baltimore County, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 29 1966			
25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Cook Wm. <del>XXXX</del> -Brooks Inc. Baltimore, Md.			

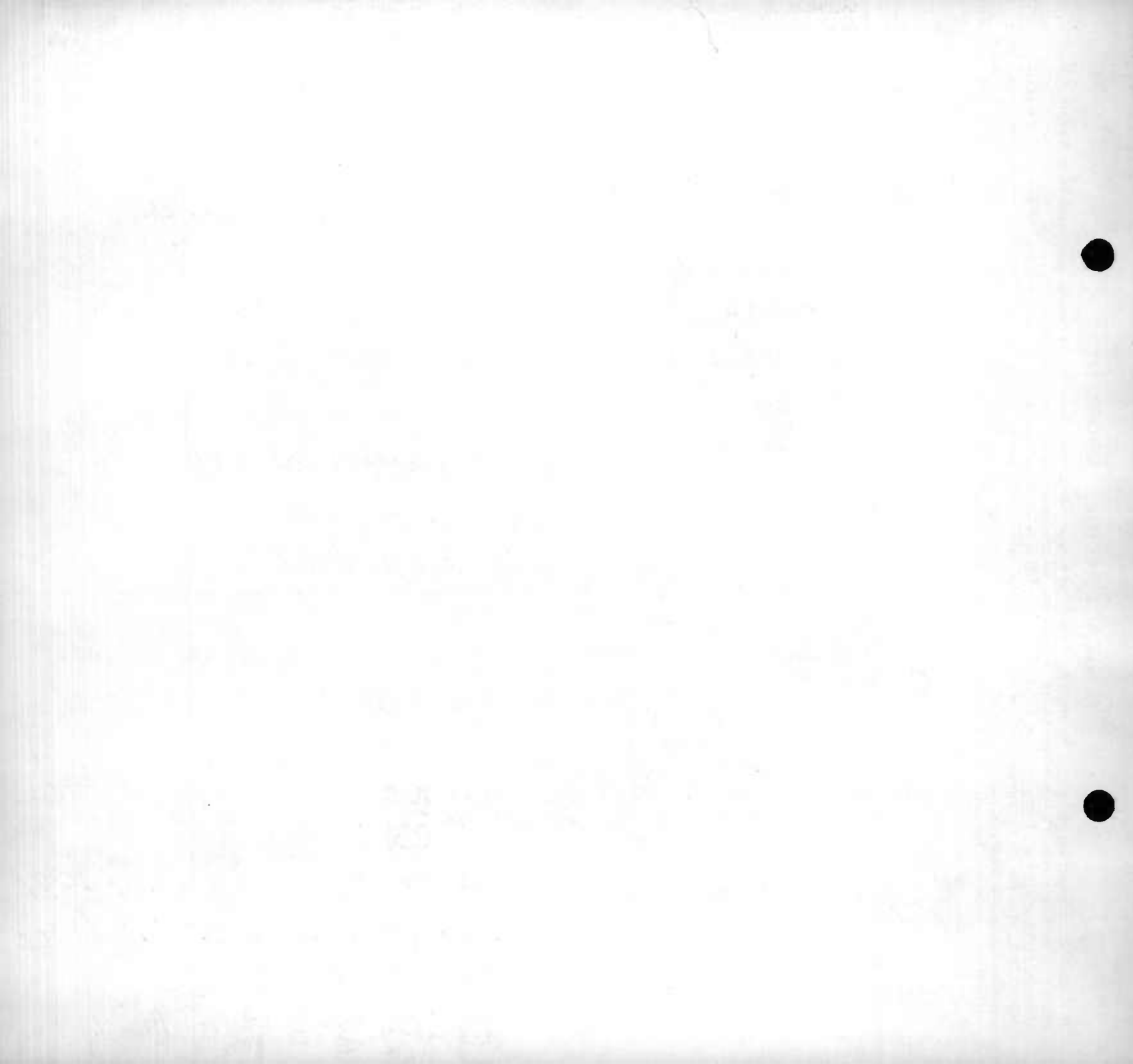
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>2-525</p> <p>66 09807</p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>Registered No. 66 09807</p>	
<p>BIRTH NO.</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <i>Seneca Williams Johnson</i></p>		<p>2. DATE AND HOUR OF DEATH <i>Sept 28 1966</i> M.</p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <i>8910 N. Washington ST.</i></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>6-04</i> D. STREET ADDRESS (If rural, give location) <i>110 N. Washington St</i></p>	
<p>5. SEX <i>Female</i></p>	<p>6. RACE <i>Colored</i></p>	<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i></p>	<p>8. DATE OF BIRTH <i>May 7-1901</i></p>
<p>9. AGE (In years lost birthday) <i>65</i></p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i></p>	<p>11. BIRTHPLACE (State or foreign country) <i>Richmond Va</i></p>	<p>12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i></p>
<p>13. FATHER'S NAME <i>William Norris</i></p>		<p>14. MOTHER'S MAIDEN NAME <i>Hankus Norris</i></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i></p>		<p>16. SOCIAL SECURITY NO.</p>	<p>17. INFORMANT ADDRESS</p>
<p>18. <i>2877X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH (A) <i>Hypertension + arteriosclerotic CVD</i> DUE TO (B) <i>General arteriosclerosis</i> DUE TO (C) <i>Marked Obesity</i></p>	
<p>INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			
<p>19A. DATE OF OPERATION <i>none</i></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No)</p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no accident</i></p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>	<p>21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>March 12 1965</i> to <i>Sept 16 1966</i>, that (I) (we) last saw the deceased alive on <i>Sept 16 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>Jacob M. Miller</i> M.D.</p>		<p>23B. DATE SIGNED <i>Sept 28/66</i></p>	
<p>23C. PHYSICIAN'S NAME (Type) <i>Jacob M. MILLER</i> M.D.</p>		<p>23D. ADDRESS <i>1613 E Baltimore St Baltimore Md</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i></p>	<p>24B. DATE <i>10-1-66</i></p>	<p>24C. NAME OF CEMETERY OR CREMATORY <i>Not Arbore Cent</i></p>	<p>24D. LOCATION (City, town, or county) (State) <i>Baltimore</i></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <i>SEP 29 1966</i></p>	<p>25B. NAME OF REGISTRAR <i>Robert E. Taylor</i></p>	<p>25C. FUNERAL DIRECTOR <i>Chas O. Wilson</i></p>	<p>ADDRESS <i>1000 Broadway Ave.</i></p>



1		66 09808		BALTIMORE CITY HEALTH DEPARTMENT		66 09808	
BIRTH NO.				MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
Nathaniel (Folkes) Fowlkes				9/19/66 10:30 a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
				A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
90 1219 W. Fayette St.				Baltimore 16-01			
D. STREET ADDRESS (If rural, give location)				814 N. Fremont Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
male	colored		5/21/19	47			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Virginia		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Cleveland Fowlkes				Ellen Booker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
		227-01-6011		Lucille White 1009 Olive St.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Carcinoma of larynx DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				no			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 9/19/66							
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		9/27/66		Mt. Calvary		Brooklyn XMA Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
SEP 29 1966		Charles A. Rice		Charles A. Rice		661 W. Barre St.	



WALLING FORT



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09809		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09809	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Jennie Vanlandingham		2. DATE AND HOUR OF DEATH 9-27-1966 5:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 25-32			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21228			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 2801 JO PHEA AVE			
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-24-01	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Louis Gross		14. MOTHER'S MAIDEN NAME Maggie		ADDRESS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Records.		
18. 260X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Uncontrolled diabetes m. 2 yrs. DUE TO (B) Gangrene. DUE TO (C) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Hypertension			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 9-9-19 66 to 9-27-19 66, that (we) lost saw the deceased alive on 9-27-19 66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Beresford M. Swan		M.D.	Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 9-27-66.	
23C. PHYSICIAN'S NAME (Type) Beresford M. Swan		M.D.	23D. ADDRESS South Baltimore General Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/6/66	24C. NAME OF CEMETERY or CREMATORY Carver Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles A. Rice	
				ADDRESS 661 W. Barre St	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09810		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09810	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) REMPTON, BERTHA COX		2. DATE AND HOUR OF DEATH 26 SEPT 66 6:20 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSP		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Towson			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 509 E. TOPPA RD			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-4-86	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CHARLES E. COX		14. MOTHER'S MAIDEN NAME ELIZABETH ELINE PETER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Palmer Hobday 201 Murdock Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <del>Stroke</del> DUE TO Lymphoma of Neck (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 15 SEPT 19 66 to 20 SEPT 19 66, that (I) (we) last saw the deceased alive on 26 SEPT 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sidney E. Kirkley		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 26 SEPT 66	
23C. PHYSICIAN'S NAME (Type) SIDNEY E. KIRKLEY,		23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/30/1966	24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1966		25B. NAME OF REGISTRAR R. E. E. E.		25C. FUNERAL DIRECTOR Wm. J. Trimmer & Sons	
25D. ADDRESS Baltimore, Md. North & Pa. Aves.					

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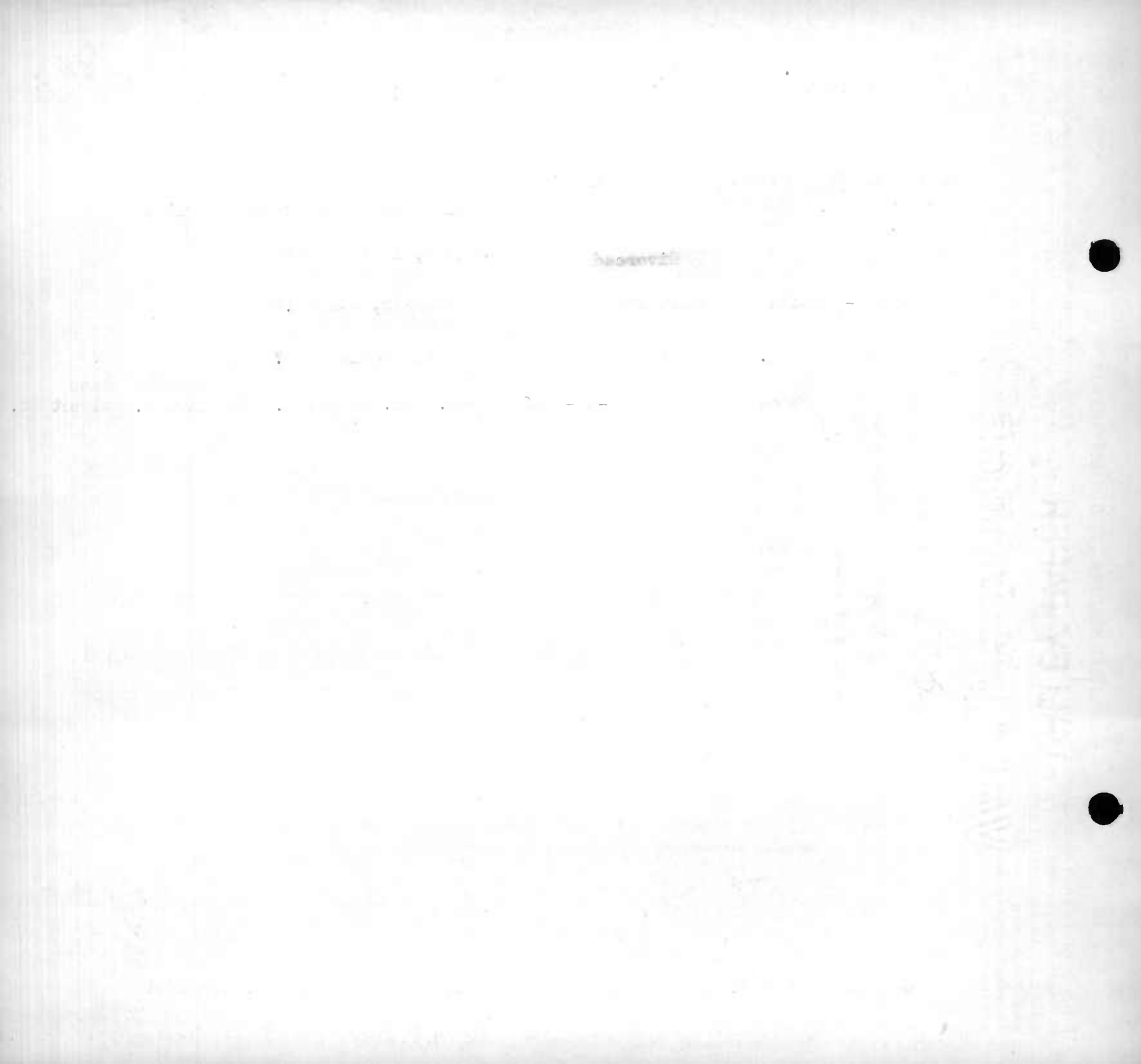
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09811</b>	
66 09811					
BIRTH NO.					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>Edna B. Schenck</b>			2. DATE AND HOUR OF DEATH <b>9-27-66 5:55 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>House In the Pines Nursing Home 90 2525 W. Belvedere Ave.</b>			A. STATE <b>Maryland</b>		
(If not in hospital or institution, give street address or location)			B. COUNTY		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			D. STREET ADDRESS (If rural, give location) <b>916 Saint Paul Street 21202</b>		
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Divorced</b>	
8. DATE OF BIRTH <b>June 6, 1888</b>		9. AGE (In years last birthday) <b>78</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Auditor</b>	
11. BIRTHPLACE (State or foreign country) <b>Chicago, Illinois</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Martin B. Schenck</b>	
14. MOTHER'S MAIDEN NAME <b>Ada Marie ?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>098-05-4112</b>	
17. INFORMANT <b>Brig. Gen. Eugene S. Bibb</b>		ADDRESS <b>Horizon House 1101 N. Calvert St.</b>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>None</b>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>None</b>		21. DATE OF OPERATION <b>0 None</b>		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		25. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		27. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		28. INJURY OCCURRED	
29. HOW DID INJURY OCCUR?		30. WHILE AT WORK		31. NOT WHILE AT WORK	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1964</b> to <b>Sept 1966</b> , that (I) (we) last saw the deceased alive on <b>9/16/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Emmett Queen</b>				23B. DATE SIGNED <b>9/28/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. EMMETT QUEEN M.D.</b>				23D. ADDRESS <b>Med. Arts Bldg - Baltimore</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>9/29/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenmount Crematory</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1966</b>		25B. NAME OF REGISTRAR <b>Wm. J. Dickert</b>	
25C. FUNERAL DIRECTOR <b>Baltimore Ind. North Pa. Ave.</b>		25D. ADDRESS		25E. ADDRESS	



m-324

66 09812

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09812

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
TIMOTHY MITCHELL		September 23, 1966 1:50 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION  116 N. Pine Street		A. STATE Maryland	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore 4-02	
		D. STREET ADDRESS (If rural, give location)	
		116 N. Pine Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Male	Negro	Widowed	9. AGE (In years last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country)	
		Maryland ?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Unknown		Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No			
		17. INFORMANT	
		Lillie Green 306 N. Parrish Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
443X I		Hypertensive and arteriosclerotic	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		XXXXXX heart disease	
		(B) DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Malnutrition	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED	
Charles S. Springate, M.D.		September 23, 1966	
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	9/28/66	Mt Calvary Cemetery	Ann Arundel County, Md.
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS	
SEP 29 1966	Wm. C. March	928 E. North Ave.	

VALLENT POLICE

VALLENT POLICE

VALLENT POLICE

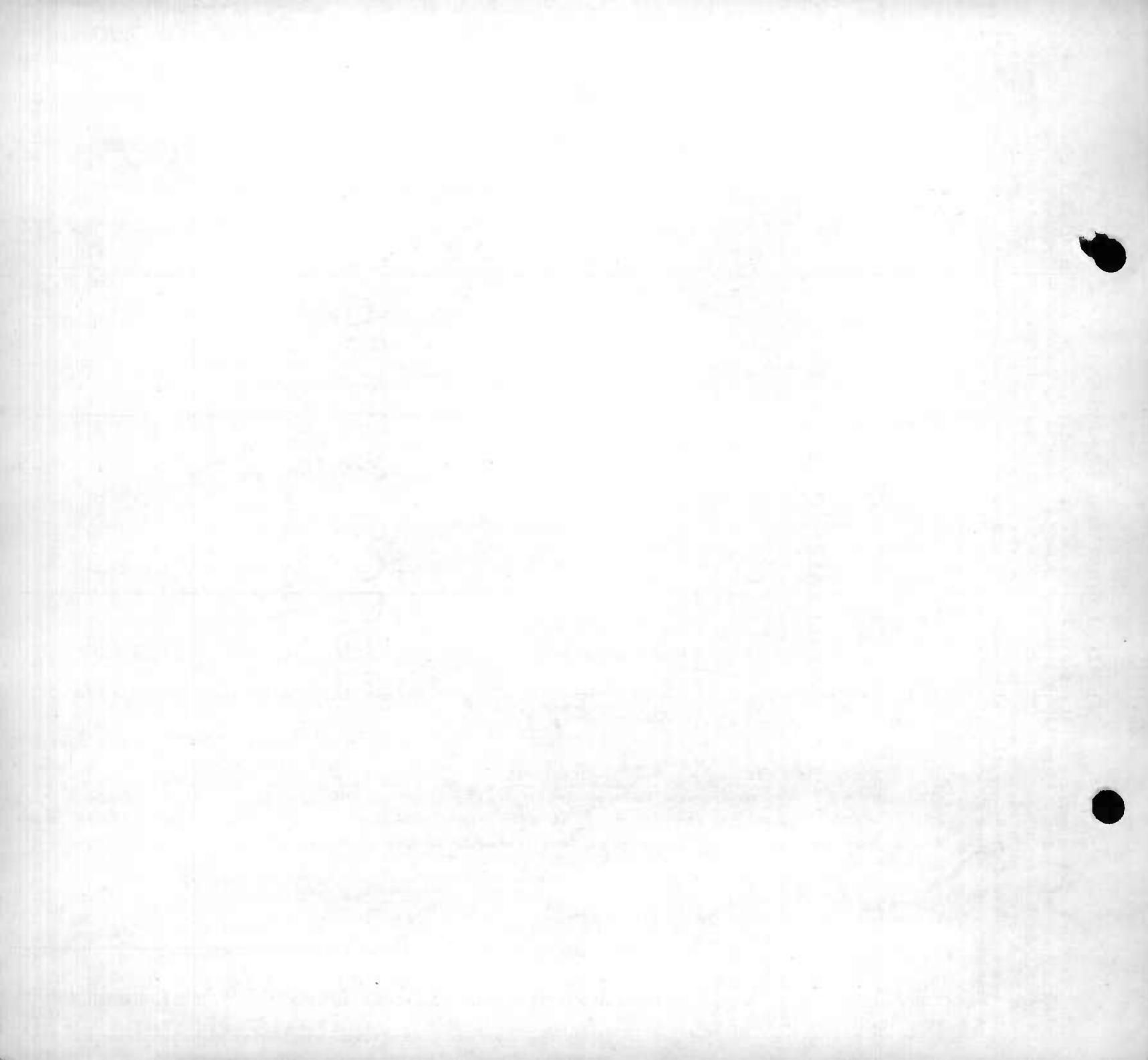
VALLENT POLICE



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-21163 66 09813		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09813	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Girl Robinson		2. DATE AND HOUR OF DEATH 9/27/66 2:45 AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
33 Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 8-06	
		D. STREET ADDRESS (If rural, give location)		1800 FEDERAL ST.	
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) N/A	8. DATE OF BIRTH 9/26/66	9. AGE (In years last birthday) <1 day	10. If Under 1 Yr. Months Days 5 15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	10B. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (State or foreign country) BALTIMORE MD.	12. CITIZEN OF WHAT COUNTRY? USA.		
13. FATHER'S NAME Fleming		14. MOTHER'S MAIDEN NAME Martha			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Prematurity (B) Premature Labor (C)		INTERVAL BETWEEN ONSET AND DEATH 5 hr 15 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2 N/A	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) N/A	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) N/A	21E. INJURY OCCURRED While At Work <input type="checkbox"/> N/A Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? N/A			
22. I certify that (I) (this hospital) attended the deceased from 9/26/66 19 66 to 9/27 19 66 that (I) (we) last saw the deceased alive on 9/27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James B. Brayton		M.D.	Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) James B. Brayton		M.D.	23D. ADDRESS the Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION	24B. DATE 9-27-66	24C. NAME OF CEMETERY or CREMATORY Johns Hopkins Hospital		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD 21205	
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1966	25B. NAME OF REGISTRAR R. E. Taylor	25C. FUNERAL DIRECTOR		ADDRESS MORTUARY SERVICE - BCHD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

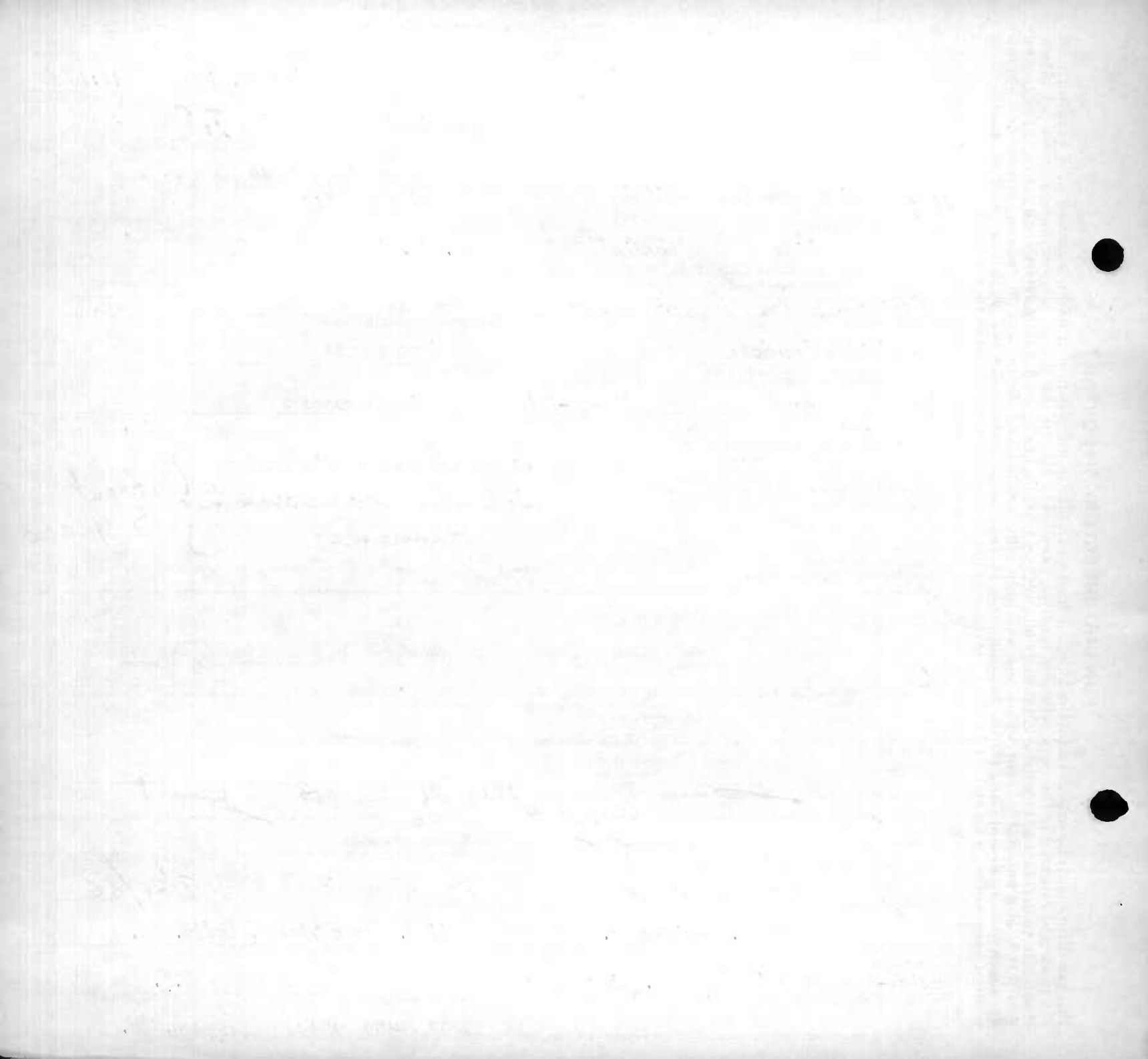
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09814</u>	
BIRTH NO. <u>66 09814</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>James D. Tuttle</u>		2. DATE AND HOUR OF DEATH <u>September 26th, 1966</u>   <u>3:45</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Saint Agnes Hospital</u> <u>Caton &amp; Wilkens Aves. 21229</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Balto</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>709 Eastshire Drive 21228</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>4/14 /1907</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>construction engineer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>US Gov. G.S.</u>		11. BIRTHPLACE (State or foreign country) <u>A. Maderia, Calif.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James W. Tuttle</u>			
14. MOTHER'S MAIDEN NAME <u>Pearl R. Dixon</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WW II</u>			
16. SOCIAL SECURITY NO. <u>533-05-3875</u>		17. INFORMANT ADDRESS <u>Mrs Doris E. Tuttle 709 Eastshire Dr</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>Acute Coronary Occlusion</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
(B) <u>Coronary Atherosclerosis</u> DUE TO		(C) _____		<u>3 yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-19</u> 19 <u>66</u> to <u>9-26-</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-1-</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James K. Gallagher Sr.</u>				23B. DATE SIGNED <u>9-26-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>W. K. Gallagher Sr.</u>				23D. ADDRESS <u>6209 Frederick Ave. Baltimore 21228, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Sept 29, 1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Balto. National Cem</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>		25C. FUNERAL DIRECTOR <u>STERLING FUNERAL ESTATE</u>			
25D. ADDRESS <u>736 Edm. Av</u>		25E. ADDRESS <u>Catonsville, Md.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

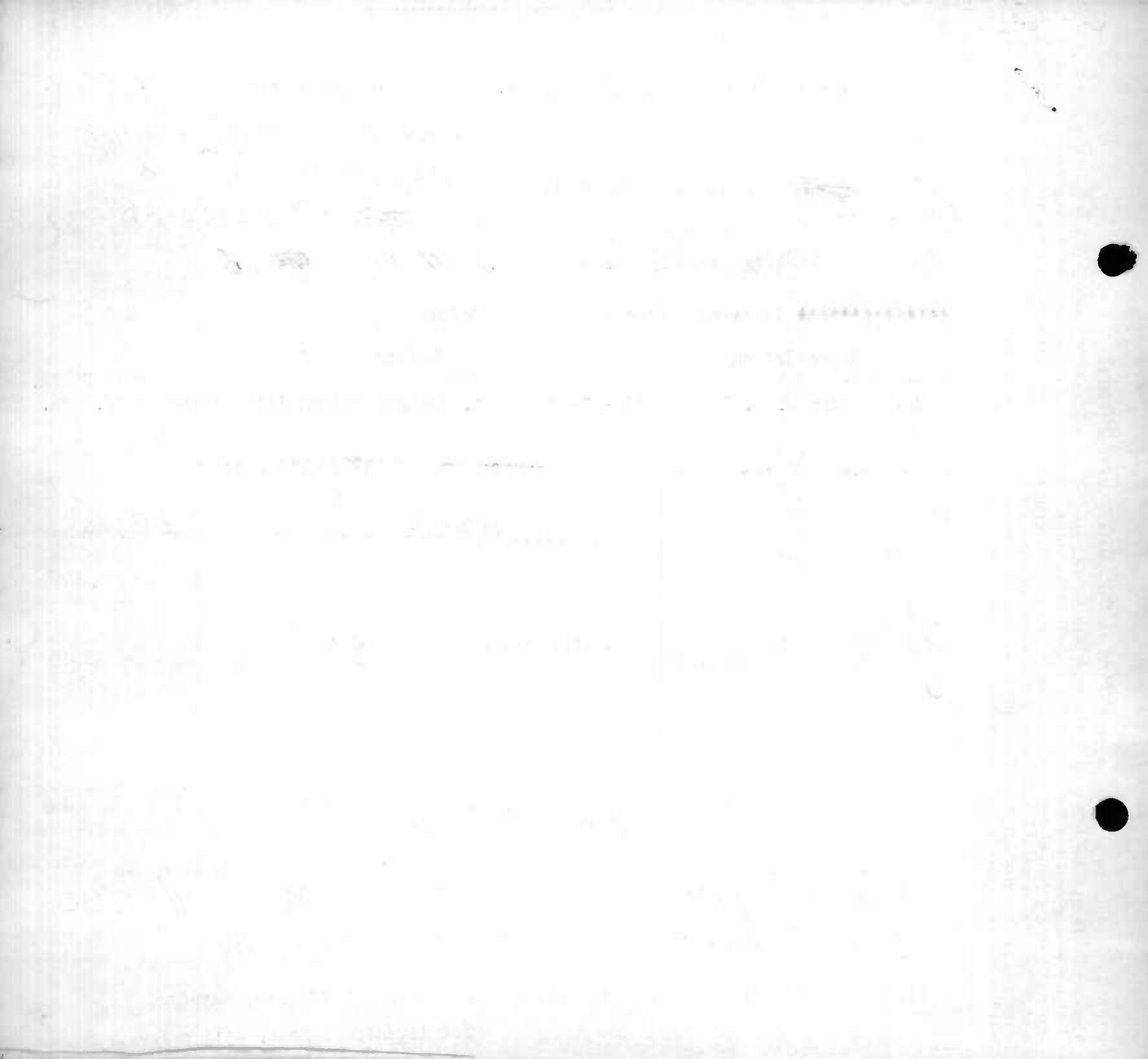
BIRTH NO. 66 09815		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09815	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Bertram Harry Crandall</i>			September 26, 1966 11:10 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>44 Union Memorial Hospital</i>			A. STATE <i>Maryland</i> B. COUNTY <i>27-38</i>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>5730 Fenwick Avenue</i>		
			D. STREET ADDRESS (If rural, give location) <i>Baltimore City</i>		
5. SEX <i>Male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>Aug. 13, 1907</i>	9. AGE (In years last birthday) <i>59</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Claims adjustor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Ford Dealer</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Melville Crandall</i>		14. MOTHER'S MAIDEN NAME <i>Blanche Case</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no none</i>		16. SOCIAL SECURITY NO. <i>225-10-1511</i>		17. INFORMANT <i>Family records</i>	
18. <i>443 X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Hypertensive, arterio-sclerotic cardiovascular</i>		<i>about 5 years</i>	
ANTECEDENT CAUSES		(B) DUE TO <i>disease</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>May 21, 1965</i> to <i>present</i> 19 <i>66</i>		that (I) <i>we</i> last saw the deceased alive on <i>August 4</i> 19 <i>66</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>we</i> (did not) view the body after death.	
23A. SIGNATURE <i>W B Daniels, Jr</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>9/26/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Worth B. Daniels Jr.</i>		23D. ADDRESS <i>11 E. Chase Street, Balto. Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial-transit</i>		24B. DATE <i>9/29/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Ft. Lincoln Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 29 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>John Barnes Sons</i>		ADDRESS <i>Towson, Md.</i>			



# FUNERAL DIRECTOR: IMPORTANT

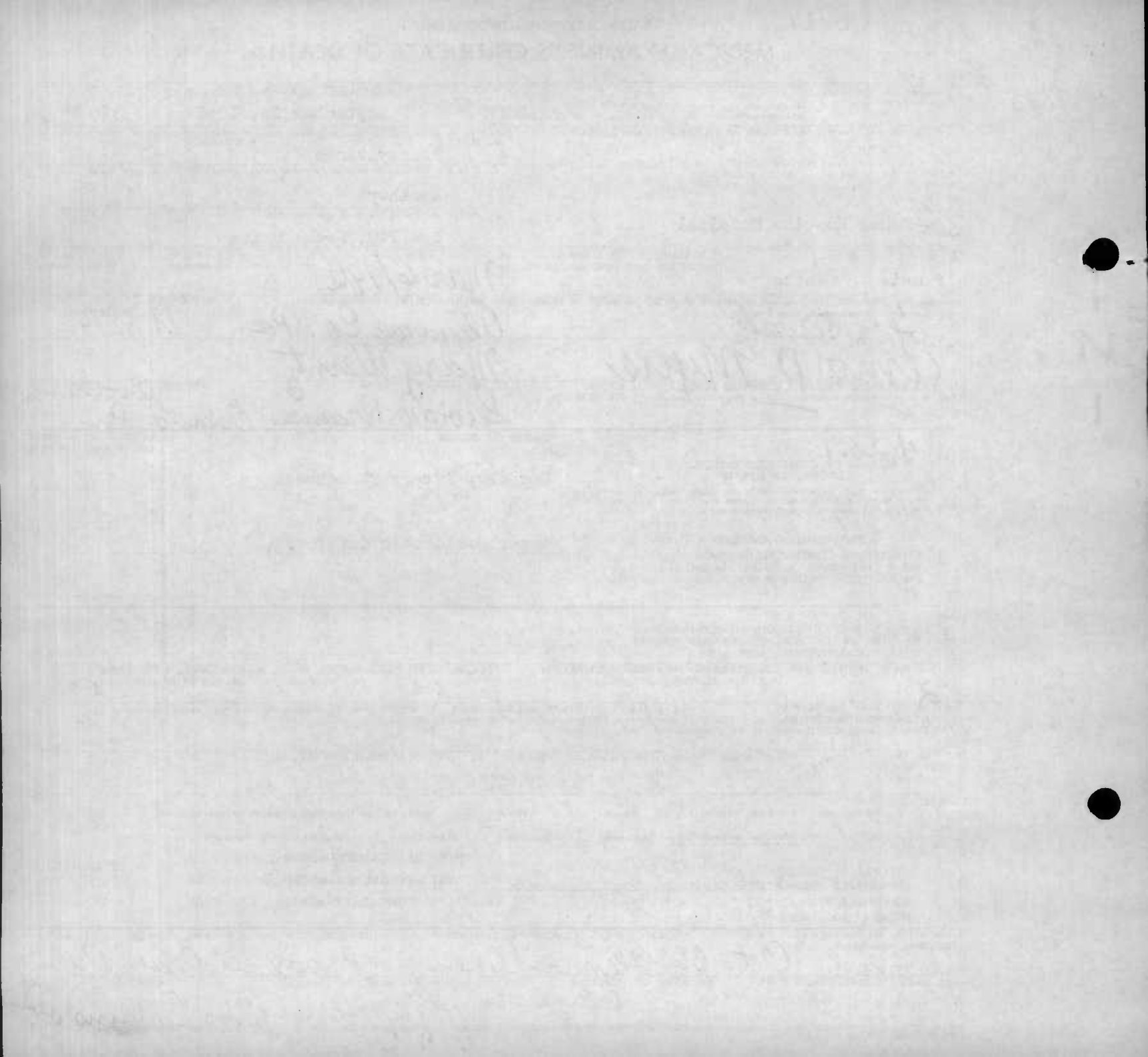
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09816		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09816	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>BERMAN, LOUIS H.</b>			2. DATE AND HOUR OF DEATH <b>9/23/66 9:29 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>4011 PIMLICO RD</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 15-13</b>		
			D. STREET ADDRESS (If rural, give location) <b>4011 PIMLICO RD</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>12 24 99</b>	9. AGE (In years lost birthday) <b>66</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman Grocery</b>			11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Isaac Berman</b>			14. MOTHER'S MAIDEN NAME <b>Shifra ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes Army W. W. I</b>			16. SOCIAL SECURITY NO. <b>216-32-8192</b>		17. INFORMANT ADDRESS <b>Phila. Mr. Haskell Berman 1815 Meribrook Rd. Pa.</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>420.11 X 260 X</b>			CAUSE OF DEATH (A) DUE TO <b>MI - CARDIAC ARREST</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO <b>ASAD</b>		
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>DIABETES MEL</b>					
19A. DATE OF OPERATION <b>9</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(1) (this hospital)</b> attended the deceased from <b>9/23 1966</b> to <b>9/23 1966</b> , that (I) (we) lost saw the deceased alive on <b>9/23 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>David Spott</b>				23B. DATE SIGNED <b>9/23/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>D.A. SPOTT</b>				23D. ADDRESS <b>SINAI HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/25/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Knesseth Israel Kolky Wolyn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1966</b>			
25B. NAME OF REGISTRAR <b>R. B. E. Fink</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Sol Levinson &amp; Bros. 6010 Reisterstown Rd.</b>			





BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 66 09817	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) LILLIAN N. KRAUSSE				2. DATE AND HOUR PRONOUNCED DEAD September 28, 1966 9:43 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pennsylvania B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boothwyn D. STREET ADDRESS (If rural, give location) Box 74G, Weeks Drive			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH Mar 6/1912	9. AGE (In years last birthday) 54	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ocala Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Amos D. Myers				14. MOTHER'S MAIDEN NAME Mary Wernitz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Lewis B. Krause Ocala Co. Pa.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
(A) DUE TO Coronary Artery Thrombosis				(B) DUE TO Arteriosclerotic Cardiovascular Disease.			
(C) DUE TO							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/29/66	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE Oct 66		23C. NAME OF CEMETERY or CREMATORY Glenwood Men.		23D. LOCATION (City, town, or county) (State) Broomall Ocala. Pa.	
24A. DATE REC'D BY HEALTH DEPT. SEP 30 1966		24B. NAME OF REGISTRAR Robert E. Fisher, M.D.		24C. FUNERAL DIRECTOR Philip Herwig Sons Orleans St		ADDRESS 2024	



1  
R-530

66 09818

BALTIMORE CITY HEALTH DEPARTMENT

66 09818

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

REIJO JUHANI RANTA

2. DATE AND HOUR PRONOUNCED DEAD

September 20, 1966 11:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Finland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Kokemaki

D. STREET ADDRESS (If rural, give location)

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

10-8-1945

9. AGE (In years  
last birthday)

20

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

SEAMAN

10B. KIND OF BUSINESS OR INDUSTRY

MARITIME

11. BIRTHPLACE (State or foreign country)

FINLAND

12. CITIZEN OF  
WHAT COUNTRY?

FINLAND

13. FATHER'S NAME

ERKKI RANTA

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

NONE

17. INFORMANT

ODDVAR NIELSEN

ADDRESS  
VICE CONSUL OF NORWAY  
MD. INDEMNITY BLDG.

18. E902.3 + 322.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Cranio-cerebral Injuries

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Acute Ethylism

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

26 Riverside Avenue

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour) (Minute)  
Sept. 20 1966 11:0021E. INJURY OCCURRED  
WHILE AT NOT WHILE  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

Fell from roof

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/21/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

9-28-1966

23C. NAME of CEMETERY or CREMATORY

OAKLAWN CEMETERY

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE COUNTY MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

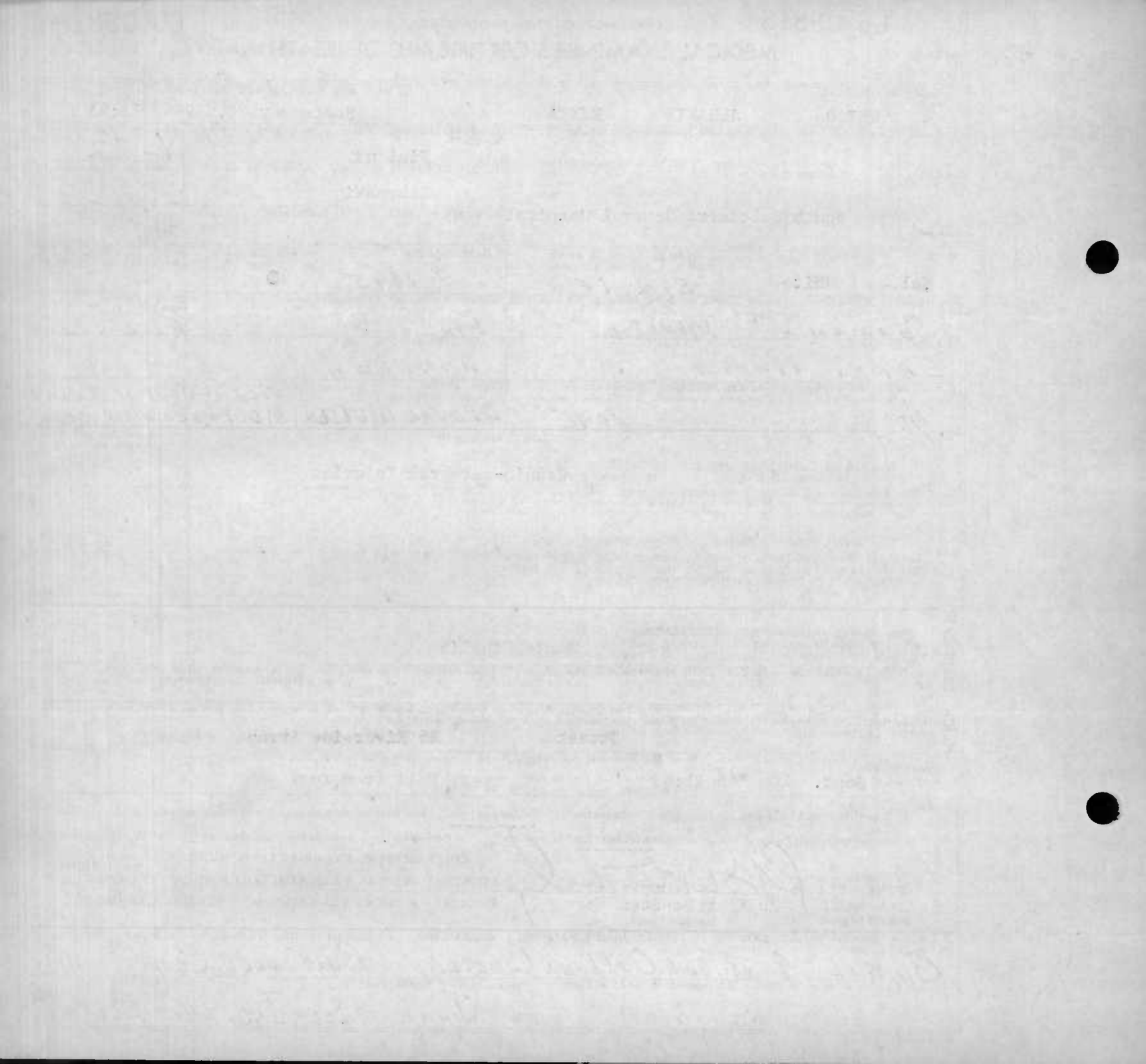
24C. FUNERAL DIRECTOR

ADDRESS

SEP 30 1966

D. E. J. J. J.

JOHN C. MILLER INC. 6415 BELAIR RD.



S-436

66 09819

BALTIMORE CITY HEALTH DEPARTMENT

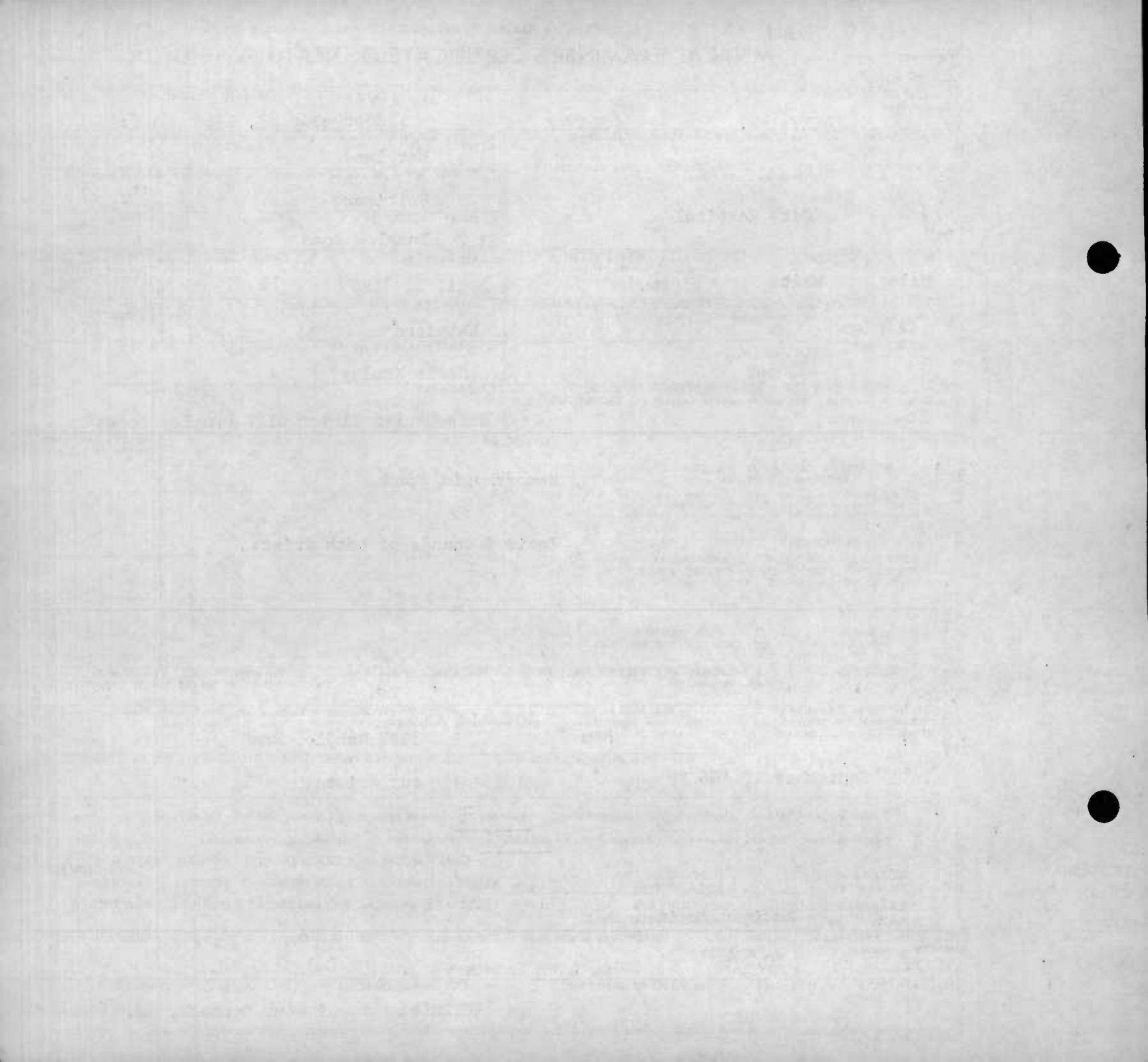
66 09819

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>HERBERT W. SLATER</b>			2. DATE AND HOUR PRONOUNCED DEAD <b>September 27, 1966 5:45 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 City Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3127 Dunglow Road</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>April 3, 1895</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Slater</b>			14. MOTHER'S MAIDEN NAME <b>Sadie Knokey</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Miss Marian Slater 3127 Dunglow Road</b>	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Hemorrhagic shock</b> (A) DUE TO II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Incised wounds of both wrists</b> (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>3127 Dunglow Road</b>	
21D. TIME OF INJURY (APPROX.) <b>September 10 '66 ?P</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>cut wrists</b>	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Rudiger Breiteneker</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Rudiger Breiteneker</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9/28/66</b>					
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>10/1/66</b>	23C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR <b>SEP 30 1966</b>		24C. FUNERAL DIRECTOR <b>Ullrich Funeral Home Dundalk, Md.</b>	

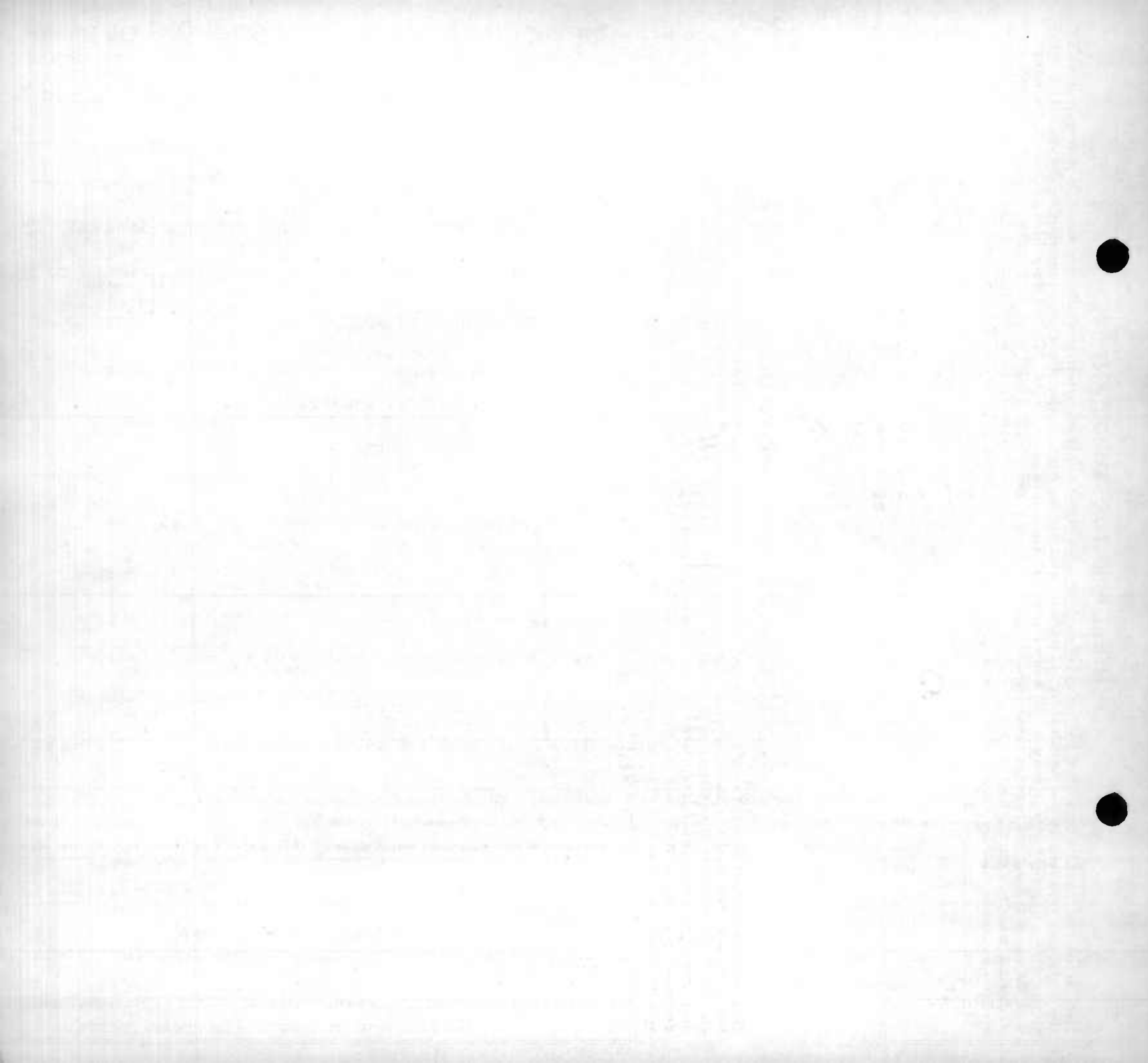




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09820		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09820	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Louisa Muller</b>			2. DATE AND HOUR OF DEATH <b>September 26, 1966</b> <b>1:45 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>House in Pines</b> <b>5837 Belair Road,</b>			A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>430 S. Highland Ave.</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 13, 1886</b>	9. AGE (In years lost birthday) <b>79</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Gegner</b>			14. MOTHER'S MAIDEN NAME <b>Mary Locherman</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>F. Leonard Muller, 430 S. Highland Ave.</b>		
18. <b>332 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertensive cardio vascular disease</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>yr 10'</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 11</b> 19 <b>66</b> to <b>Sept 26</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>Sept 23</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>George D. Lippy</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>9/28/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>George D. Lippy</b>				23D. ADDRESS <b>426 S. Patterson Park Avenue</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Entombment</b>		24B. DATE <b>9/29/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Mausoleum</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>SEP 30 1966</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Ullrich Funeral Home 4210 Belair Road.</b>			





F-600

66 09821

BALTIMORE CITY HEALTH DEPARTMENT

66 09821

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas R. Frye

2. DATE AND HOUR PRONOUNCED DEAD

9/27/66

6:25 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2111 N. Calvert St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2111 N. Calvert St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Carpenter

8. DATE OF BIRTH

April 19 1929

9. AGE (In years  
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Tenn

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Raymond Frey

14. MOTHER'S MAIDEN NAME

Bonnie Harper

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs Whitlock 1016 Pine Heights Ave

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Fatty alteration of liver  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/27/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

Sept 28/66

23C. NAME of CEMETERY or CREMATORY

Goshen Valley

23D. LOCATION

(City, town, or county)

(State)

Church Hill Tenn

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 30 1966

Ullrich Funeral Home 4210 Belair Road

WALLEY  
CO  
INC

DEC 1961

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 09822		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09822	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>Dinnell, Howard J.</u>			
2. DATE AND HOUR OF DEATH <u>25 Sept 1966</u> <u>10<sup>10</sup></u> <u>P</u> M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND General Hospital</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u>		B. COUNTY <u>Baltimore</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		27-01	
				D. STREET ADDRESS (If rural, give location) <u>4505 Simms Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>4 Nov 1914</u>	9. AGE (In years lost birthday) <u>51</u>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min:	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRANCH MANAGER, ATLACK INC.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Dinnell</u>				14. MOTHER'S MAIDEN NAME <u>Laine Dager</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>162-55-2671</u>		17. INFORMANT <u>MRS CECILIA DINNELL</u>		ADDRESS <u>4505 SIMMS</u>	
18. <u>420.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO <u>Pulmonary edema.</u>			
				(B) DUE TO <u>Adrenal apoplexy</u>			
				(C) <u>Probably due to sepsis</u> <u>Arteriosclerotic heart disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<u>Post-AR amputation of Rt leg.</u>			
19A. DATE OF OPERATION <u>25 Sept 1966</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Gas Gangrene of Leg</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>15 Sept 1966</u> to <u>25 Sept 1966</u> , that (I) (we) last saw the deceased alive on <u>25 Sept 1966</u> and that (I) (my) (our) apical death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Edward D. Laine</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>25 Sept</u>	
23C. PHYSICIAN'S NAME (Type) <u>Edward D. LAINE</u>				23D. ADDRESS <u>MARYLAND General Hospital</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9/28/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>PARKWOOD CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>PARKVILLE MD</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME</u>		ADDRESS <u>4210 BELAIR</u>	



Released on approval To The Union Memorial Hospital By Mr. Gregory 9-24-66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 09823		66 09823	
BIRTH NO.		CERTIFICATE OF DEATH	
M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
LOHMEYER, ERNEST F.		SEPT. 24 1966 1:25 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
THE UNION MEMORIAL HOSPITAL		BALTIMORE	
33RD AND CALVERT ST., BALTIMORE, MD 21218		D. STREET ADDRESS (If rural, give location) 5114 BELAIR ROAD	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
M	WHITE	YES <del>WIDOWED</del>	07-19-77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday)
RETIRED SHIPPING CLERK			89
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
BALTIMORE		AMERICAN U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
WILLIAM LOHMEYER		MARY SCHWERTZ	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		216-21-6898	
17. INFORMANT		ADDRESS	
MRS ANNA ARNESON		5114 BELAIR RD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
E900.01		Cerebral Contusion	
ANTECEDENT CAUSES		Left Parietal Skull fracture.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Epidural + Subdural Hematoma	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0			
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
<input checked="" type="checkbox"/>		Home	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		5114 Belair Rd	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	
9/23/66 7.		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		fell down cellar steps	
22. I certify that (I) (this hospital) attended the deceased from SEPT 23, 1966 to SEPT 24, 1966, that (I) (we) last saw the deceased alive on SEPT 24, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
pmc		SEPT. 24, '66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
E. F. SHAW, WILGIS M.D.		The Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
BURIAL		9/27/66	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
JERUSALEM CEMETERY		BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
SEP 30 1966		E. F. Shaw, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	
ULLRICH FUNERAL HOME		4010 BELAIR RD	

7-22-42

Sept 24

Form 100, F. 100-100

Michigan

Admission

The General Hospital

3300 and 3300 St. Adams, Michigan, 3300 and 3300

78 11-11-42

Yes

White

M

Admission

Admission

Mary Schmitt

William Schmitt

Sept 24

24

Sept 24

Sept 24

Sept 24

X

Print

E. F. Schmitt



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 09824					CERTIFICATE OF DEATH		Registered No. 66 09824		
1. NAME OF DECEASED (Type or Print) <b>THOMPSON, DONALD</b>					2. DATE AND HOUR OF DEATH <b>9-28-66 12:45A</b> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b>					A. STATE <b>MARYLAND</b> B. COUNTY <b>HOWARD</b>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>ELLICOTT CITY</b>				
D. STREET ADDRESS (If rural, give location) <b>RT 4 OLD ANNAPOLIS ROAD</b>									
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b>	8. DATE OF BIRTH <b>8-6-37</b>	9. AGE (In years last birthday) <b>29</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>VICTOR THOMPSON</b>					14. MOTHER'S MAIDEN NAME <b>LOUELLA MILLER</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>213-34-1143</b>		17. INFORMANT <b>CATON &amp; WILKENS AVES. ST. AGNES HOSPITAL RECORDS</b>				
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Multiple Myeloma</b>									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 20</b> 19 <b>66</b> to <b>SEPTEMBER 28</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>SEPTEMBER 28</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>John B Herts</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>9-28-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN B HERTS</b>					23D. ADDRESS <b>ST. AGNES HOSPITAL - CATON &amp; WILKENS</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>10-1-1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Good Shepherd</b>		24D. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 30 1966</b>			25B. NAME OF REGISTRAR <b>F.C. Higinbotham</b>		25C. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b>				

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Multiple Myeloma

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John B. Lind

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09825		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09825	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) NORA L. BLEDSOE		2. DATE AND HOUR OF DEATH SEPT. 27, 1966 14:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 19-02		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 23	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 FRANKLIN SQUARE HOSPITAL		D. STREET ADDRESS (If rural, give location) 20 N CAREY ST			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 2/17/29	9. AGE (In years last birthday) 37	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME ROY SHIPE		14. MOTHER'S MAIDEN NAME HAZEL WILKENS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Mrs. Hazel Shipe, Rt. 108, Ellicott City, Md	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 581.0 I UPPER G-I BLEEDING 5 NUTRITIONAL GASTROENTEROPATHY		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/13/66 19 to 9/27/66 19, that (I) (we) last saw the deceased alive on 9/27/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Honorio R. Ylizarde Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept. 27, 1966	
23C. PHYSICIAN'S NAME (Type) HONORIO R. YLIZARDE Jr.		M.D. 23D. ADDRESS FRANKLIN SQUARE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-1-1966		24C. NAME OF CEMETERY or CREMATORY Good Shepherd	
24D. LOCATION (City, town, or county) (State) Ellicott City, Md		25A. DATE REC'D BY HEALTH DEPT. SEP 30 1966		25B. NAME OF REGISTRAR R. D. E. T. Jones	
25C. FUNERAL DIRECTOR F. C. Higinbotham		ADDRESS Ellicott City, Md			

1943

1943

FRANKLIN SQUARE HOSPITAL

WEST VIRGINIA

20 N. CARY ST.

WHEELING

5/14/52

WHEELING

WEST VIRGINIA

1943

20 N. CARY ST.

WHEELING

1943

Upper 4-7  
to Washington

1943

FRANKLIN SQUARE HOSPITAL

WEST VIRGINIA

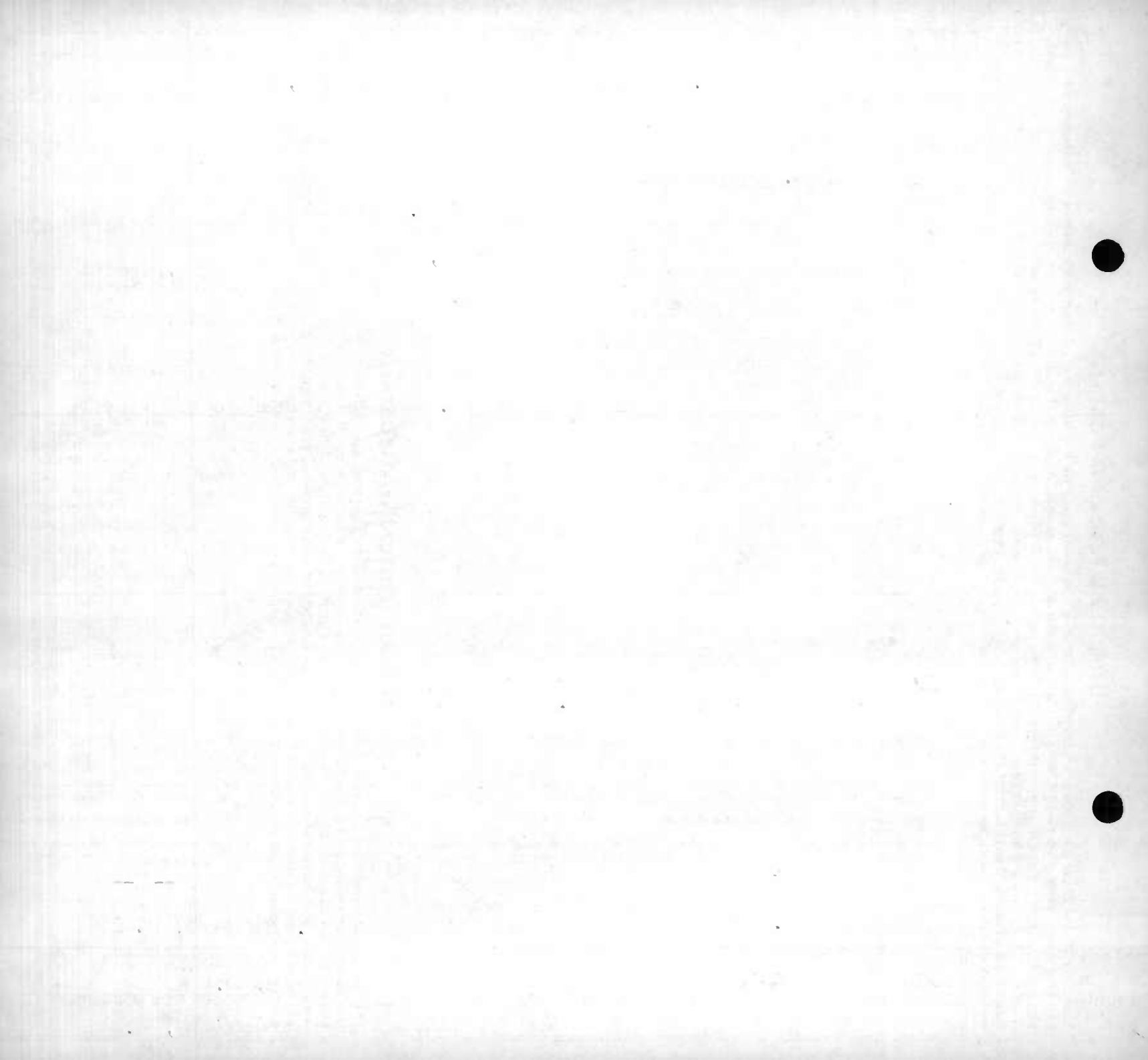
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# FUNERAL DIRECTOR: IMPORTANT

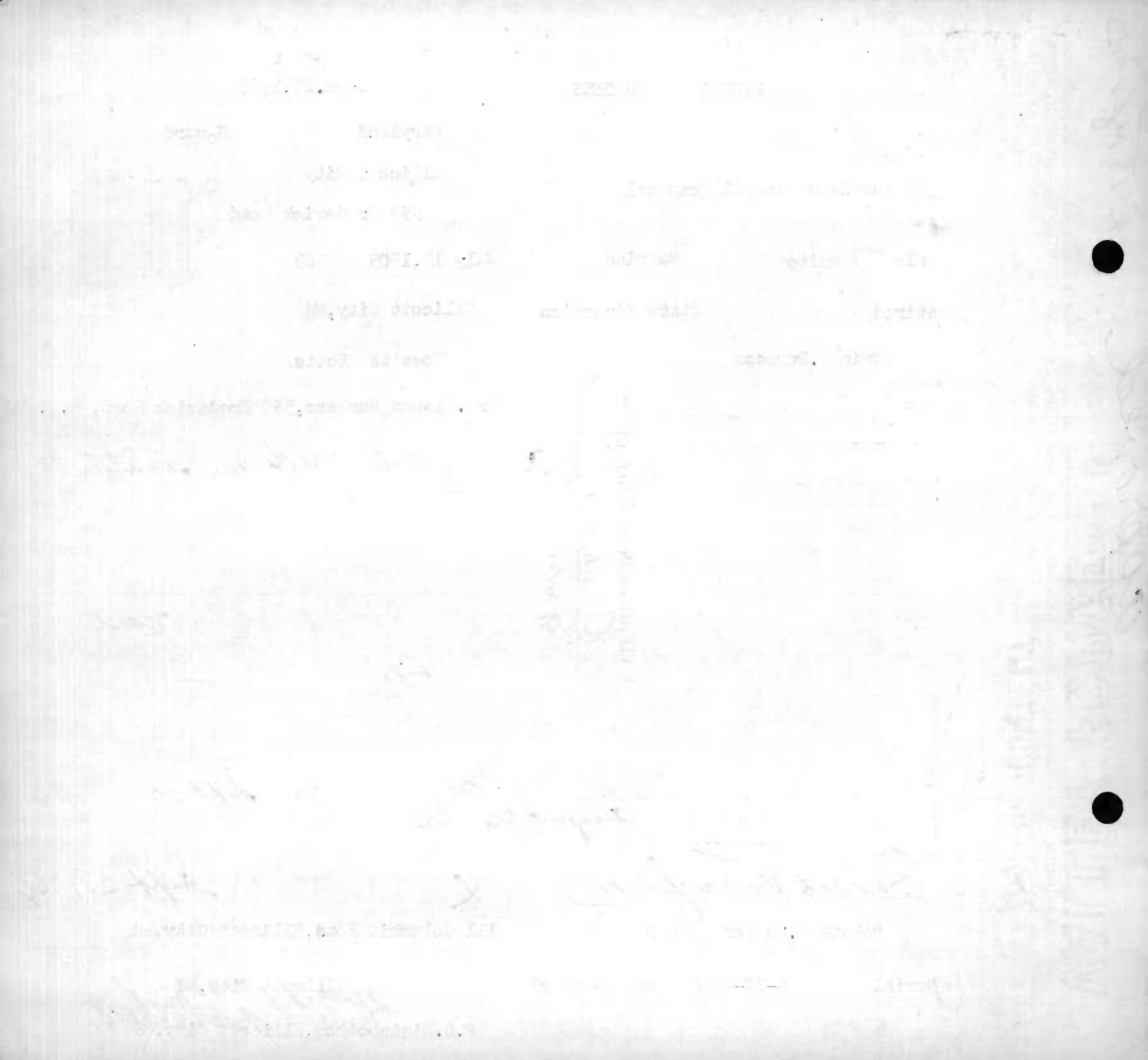
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09826</u>	
BIRTH NO. <u>66 09826</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>John F. Drechsler</u>		2. DATE AND HOUR OF DEATH <u>Sept 27, 1966</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <u>214 S. Payson Street</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>214 S. Payson St</u>			
5. SEX <u>Male</u>	6. RACE <u>Wh</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	B. DATE OF BIRTH <u>July 7, 1893</u>	9. AGE (In years lost birthday) <u>73</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Shoe</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220 30 5658 A</u>	17. INFORMANT <u>Mrs. Marie Teresa Drechsler</u>		
		ADDRESS <u>214 S Payson</u>			
18. <u>177X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <u>CARCINOMA OF PROSTATE</u> DUE TO (B) <u>Secondary Anemia</u> DUE TO (C) <u>Senility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>2 yrs</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>9</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>9/27/66</u> , that (I) (we) last saw the deceased alive on <u>9/27/66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. Calas</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>9-27-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. Calas</u>		23D. ADDRESS <u>6411 Frederick Rd. Baltimore, Md. 28</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10-1-1966</u>	24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 30 1966</u>		25B. NAME OF REGISTRAR <u>Edmund E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>Thomas J. Kenny Inc Baltimore, Md.</u>	



Approved - R.B. Taylor MD  
FUNERAL DIRECTOR: IMPORTANT  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09827		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09827	
M.E. CASE NO.		CERTIFICATE OF DEATH		Date and Hour of Death	
1. NAME OF DECEASED (Type or Print)		LIONEL BURGESS		Sept. 27, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY Howard	
48 Maryland General Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Ellicott City	
		D. STREET ADDRESS (If rural, give location)		63-00	
		558 Frederick Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	White	Married	July 13, 1903	63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired		State Education	Ellicott City, Md		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Edwin E. Burgess			Rosetta Betts		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			Mrs. Lenna Burgess, 558 Frederick Road, E.C. Md		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			M. CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Coronary artery occlusion instant		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			none.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 1960 to Sept 27 1966, that (I) (we) last saw the deceased alive on August 26 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Robert B. Taylor MD				Sept 28, 1966	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Robert B. Taylor M D				M.D. 111 Columbia Road, Ellicott City, Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		9-30-1966		Good Shepherd	
				Ellicott City, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 30 1966		R. B. Taylor, MD		F. C. Higinbotham, Ellicott City, Md	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09828

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WALTER

JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

September 25, 1966

1:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2208 W. Lexington Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

8-25-1907

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Track Foreman

10B. KIND OF BUSINESS OR INDUSTRY

B+O Railroad

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Johnson

14. MOTHER'S MAIDEN NAME

Esabelle Boardley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

705-07-4080

17. INFORMANT

Mrs. Laura Johnson - Balto., Md.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cranio-cerebral Injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Rear of 405 Franklin town Road

21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

September 17/66 10:55

21E. INJURY OCCURRED  
WHILE AT WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently fell during an assault

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/25/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

9-28-66

23C. NAME of CEMETERY or CREMATORY

St. Luke's Cemetery

23D. LOCATION

(City, town, or county)

Sykesville,

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 30 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

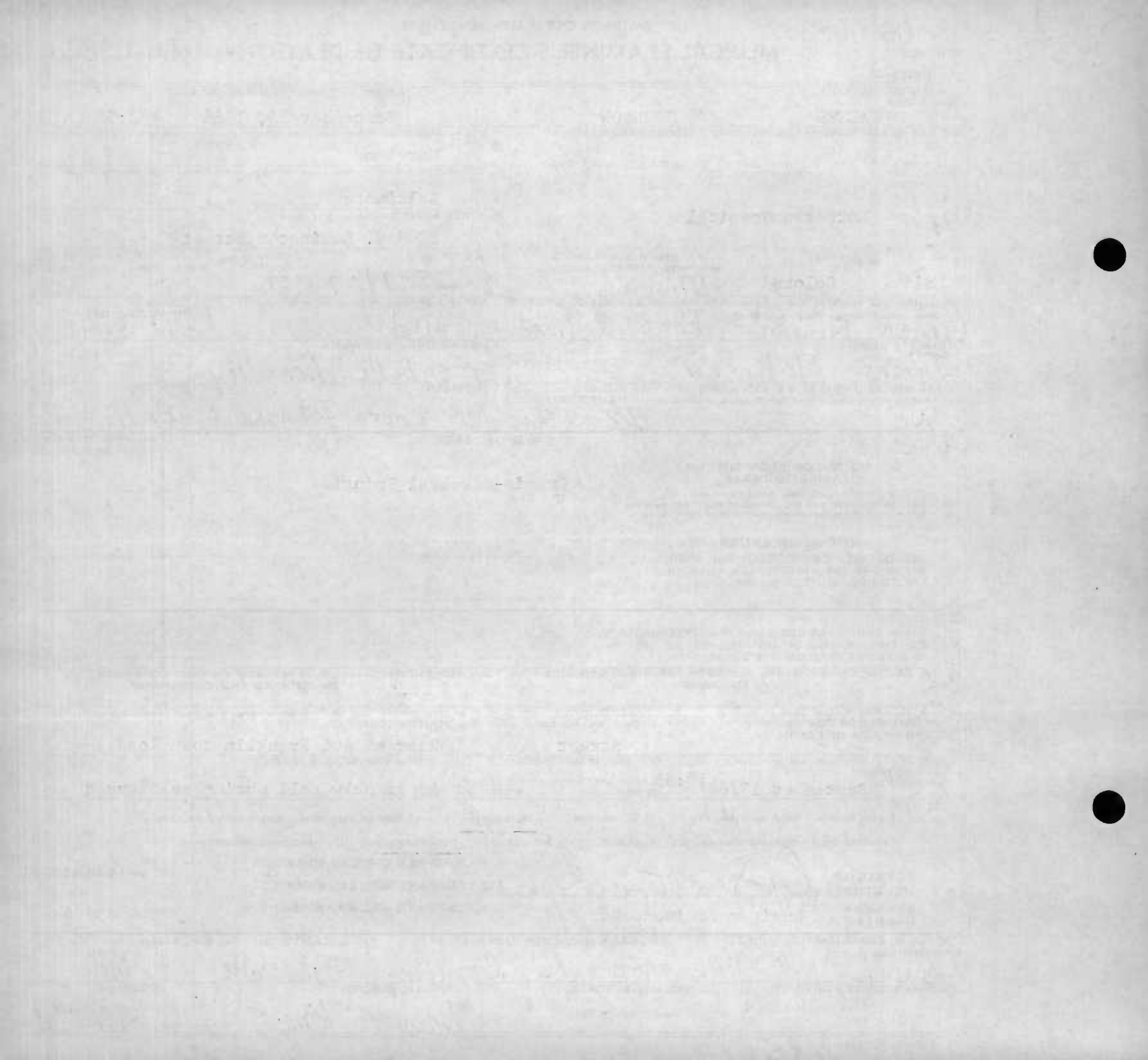
24C. FUNERAL DIRECTOR

Harry W. Haight

ADDRESS

Sykesville, Md.

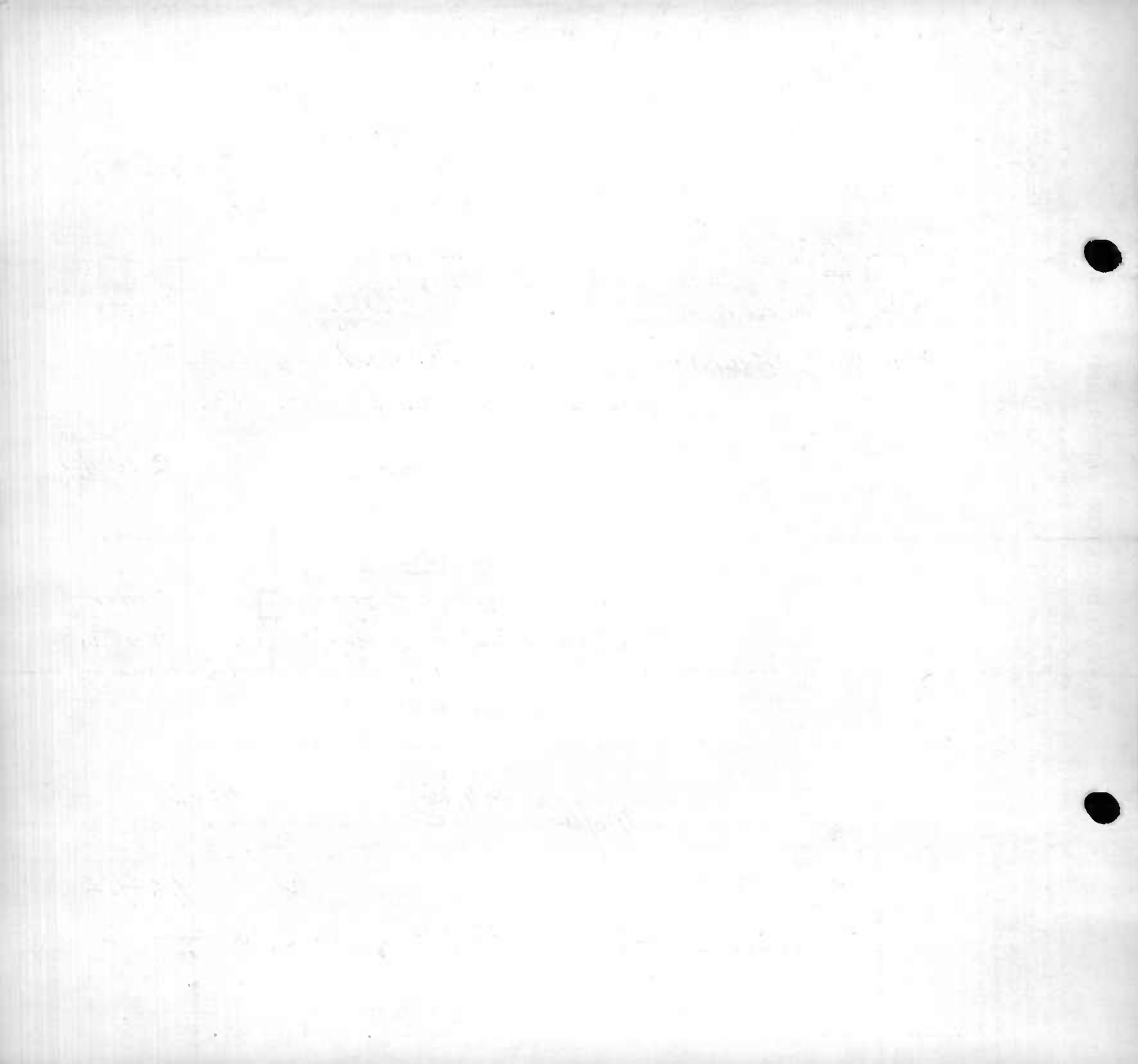






This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 09829		CERTIFICATE OF DEATH		66 09829	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Kamphaus, Charles N.		9/28/66		8:35 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
91 Montebello State Hospital		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		502 H. Mellon Ave.			
5. SEX	6. RACE	7. MARRIED/NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	White		9/29/1883	82	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Lab. Technician		Hynson Westcott Dunning Inc.		Baltimore Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John Henry Kamphaus		Theresa Augusta Thumser			
16. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		215-03-6238		Mary E. Kamphaus, dght, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
493 X I		(A) Pneumonia		2 weeks	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II		Other Significant Conditions Contributing to the Death but not related to the disease or condition causing it.		years months	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/4/66 to 9/28/66, that (I) (we) last saw the deceased alive on 9/28/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Daniel G. Lai				9/28/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DANIEL G. LAI		3201 Argonne Drive, Baltimore 14, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	10/1/66	Parkwood Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 30 1966		Robert E. Tally		Schimunek Funeral Home, Inc. 2601 E. Madison St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>66 09830</b>		<b>CERTIFICATE OF DEATH</b>		66 09830	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>MARGARET A. Sieber</b>			2. DATE AND HOUR OF DEATH <b>9-28-66 5<sup>10</sup> P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>37 Mercy Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWNSHIP (If outside city limits, write RURAL and give township) <b>Dudley Ave. #13</b> D. STREET ADDRESS (If rural, give location) <b>26-03</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1-5-04</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Typist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Finance Corp. of America</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Philip Brenneis</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Preller</b>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-10-1385</b>		17. INFORMANT <b>William A. Sieber, Husband, 3543 Dudley Ave.</b>	
18. <b>443 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Embolism</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>Chr. Atrial fibrillation 4 yrs</b>		
			(C) <b>Hypertensive Cardiovascular Dis 4 yrs</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>Phlebotis @ L.E. 4 yrs</b>		
			<b>Congestive Heart Failure 3 wks</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/31/66</b> 19 <b>66</b> to <b>9/28</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/28</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Michael J. Rokoff</b>			23B. DATE SIGNED <b>9/28/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Michael J. Rokoff</b>			23D. ADDRESS <b>Mercy Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/1/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 30 1966</b>			
25B. NAME OF REGISTRAR <b>John E. Farley</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>			
25D. ADDRESS <b>3331 Brehms Lane #13</b>					

U. S. P.

24

1875

July 1st 1875

M. J. 1875

July 1st 1875

PS

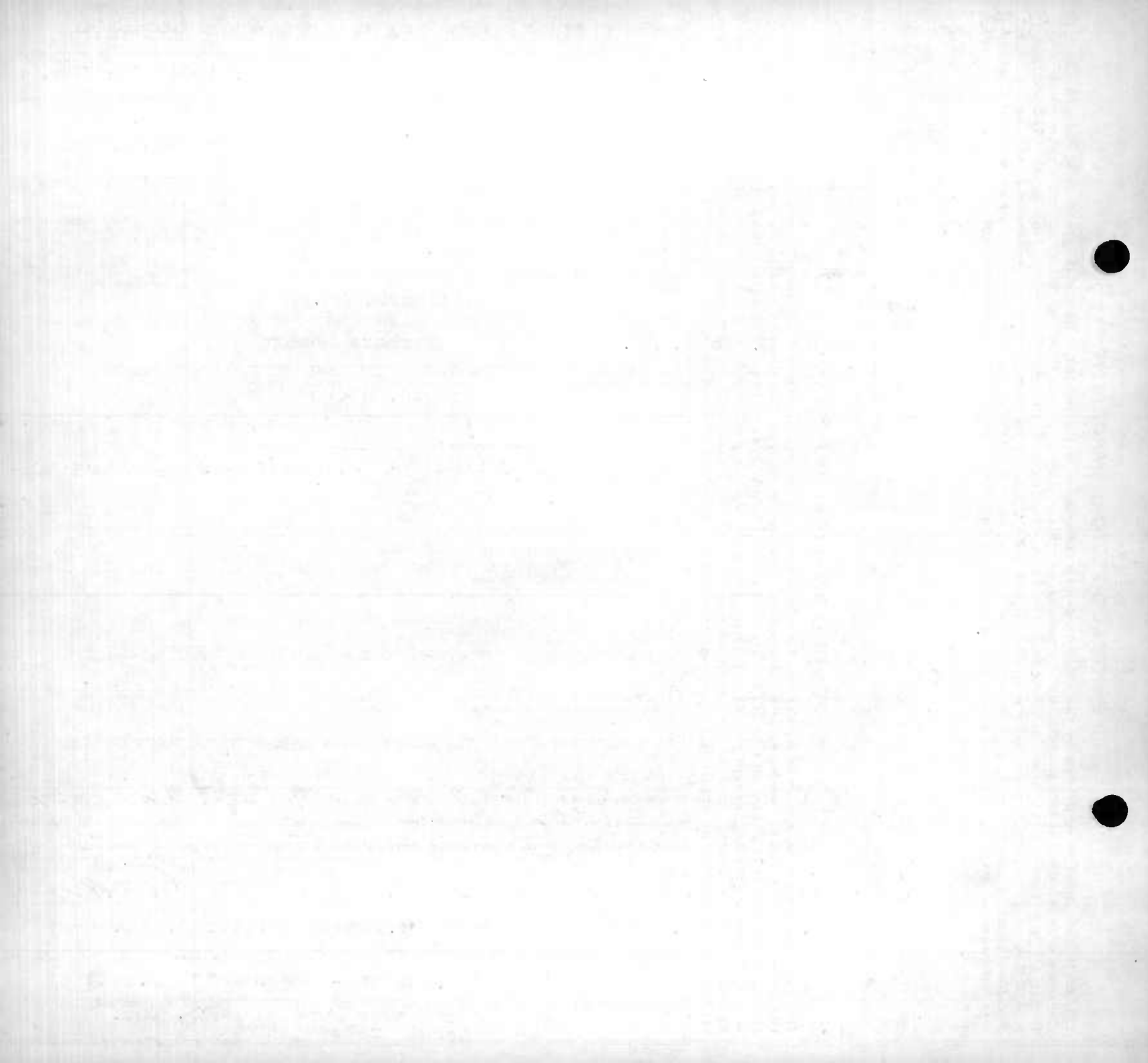
July 1st 1875

July 1st 1875

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

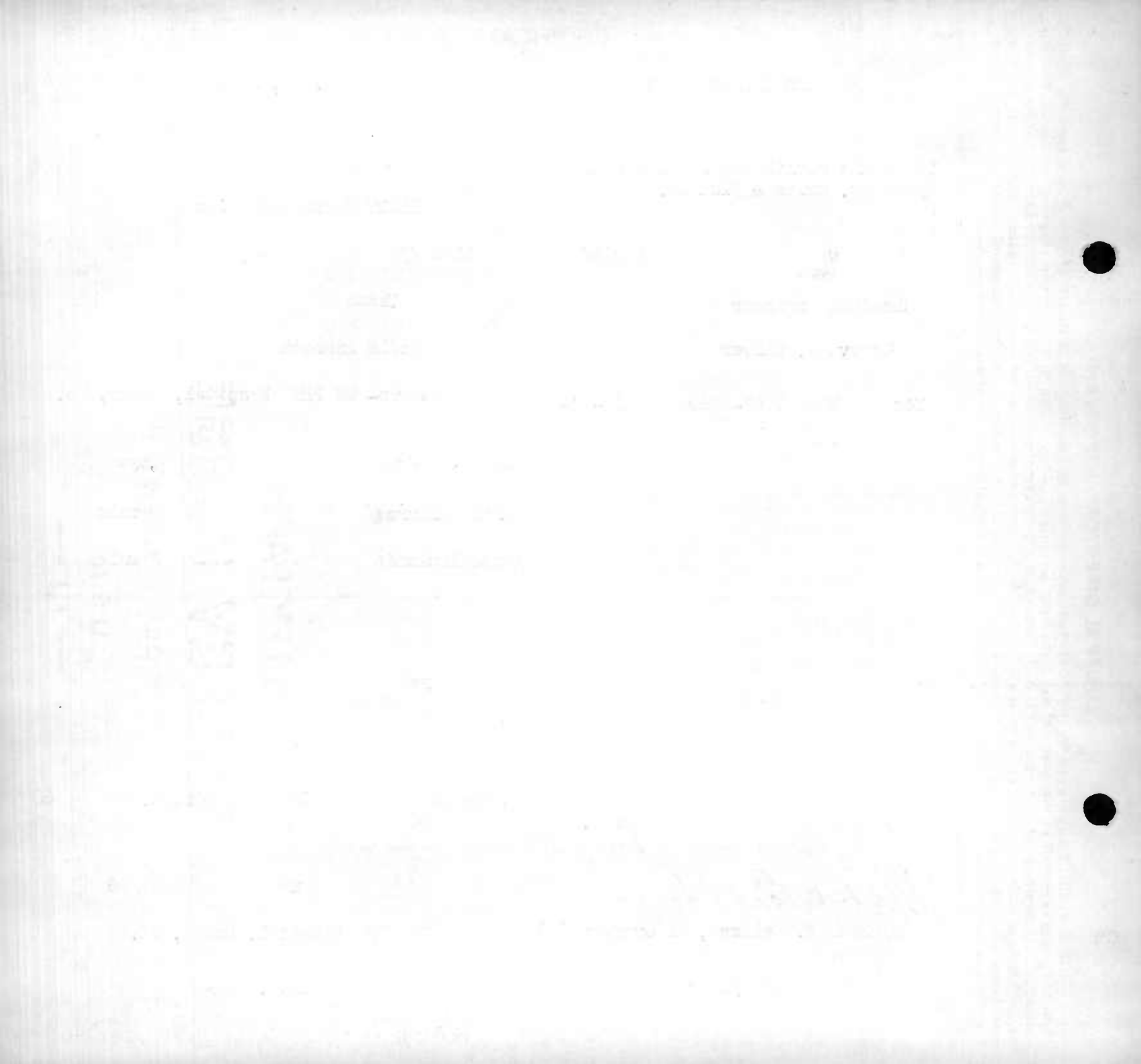
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09831	
BIRTH NO. 66 09831		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LOUIS G. POHL 3rd		2. DATE AND HOUR OF DEATH September 27, 1966 12:10 a. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  37 Mercy Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Lutherville D. STREET ADDRESS (If rural, give location) 1708 Green Spring Drive		
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH 7/2/56	9. AGE (In years last birthday) 10	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Louis G. Pohl, Jr.			14. MOTHER'S MAIDEN NAME Barbara Seward		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Parents, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  241X I status Asthmaticus			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 hours
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 7 1959 to Sept 26 1966, that (I) (we) last saw the deceased alive on Sept 26 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George T. Gilmore				23B. DATE SIGNED 9/27/66	
23C. PHYSICIAN'S NAME (Type) Dr. George T. Gilmore		23D. ADDRESS York Rd., Lutherville, Md. (Lanahan Bldg)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/30/66		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem. Gardens-200 Padonia Rd. East	
25A. DATE REC'D BY HEALTH DEPT. SEP 30 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09832	
<div> <div>BIRTH NO. 66 09832</div> <div>CERTIFICATE OF DEATH</div> </div>					
<div> <div>M.E. CASE NO.</div> <div>1. NAME OF DECEASED (Type or Print) <b>Leaton Thomas Oliver</b></div> </div>			<div> <div>2. DATE AND HOUR OF DEATH</div> <div>Sept. 29, 1966 2:15 A M.</div> </div>		
<div> <div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION</div> <div>US Public Health Service Hospital</div> <div>Wyman Pk. Drive &amp; 31st St.</div> </div> </div>			<div> <div>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</div> <div> <div>A. STATE</div> <div>La.</div> </div> <div> <div>C. CITY OR TOWN (If outside city limits, write RURAL and give township)</div> <div>Baton Rouge</div> </div> <div> <div>D. STREET ADDRESS (If rural, give location)</div> <div>11227 Glenhaven Drive</div> </div> </div>		
<div> <div>5. SEX</div> <div>M</div> </div>	<div> <div>6. RACE</div> <div>W</div> </div>	<div> <div>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</div> <div>Married</div> </div>	<div> <div>8. DATE OF BIRTH</div> <div>12/29/39</div> </div>	<div> <div>9. AGE (In years last birthday)</div> <div>26</div> </div>	<div> <div>If Under 1 Yr. Months: Days: Hours: Min.</div> </div>
<div> <div>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Chemical Engineer</div> </div>			<div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>Texas</div> </div>		<div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div> </div>
<div> <div>13. FATHER'S NAME</div> <div>George M. Oliver</div> </div>			<div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Leila Amonett</div> </div>		
<div> <div>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> <div>Yes USA 1963-1965</div> </div>			<div> <div>16. SOCIAL SECURITY NO.</div> <div>462-64-9901</div> </div>		<div> <div>17. INFORMANT ADDRESS</div> <div>Records- US PHS Hospital, Balto, Md.</div> </div>
<div> <div>18. CAUSE OF DEATH</div> <div> <div>204.3 I</div> <div>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</div> <div>ANTECEDENT CAUSES</div> <div>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> </div> <div> <div>(A) Pulmonary edema</div> <div>DUE TO</div> <div>Renal failure</div> <div>(B) DUE TO</div> <div>Acute leukemia</div> <div>(C)</div> </div> <div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>Days</div> <div>Months</div> <div>Months</div> </div> </div>					
<div> <div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div> </div>					
<div> <div>19A. DATE OF OPERATION</div> <div>2</div> </div>		<div> <div>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> </div>		<div> <div>20A. AUTOPSY? (Yes or No)</div> <div>yes</div> </div>	
<div> <div>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</div> </div>		<div> <div>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div> </div>		<div> <div>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div> </div>	
<div> <div>21D. TIME OF INJURY (APPROX.)</div> </div>		<div> <div>21E. INJURY OCCURRED</div> <div>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div> </div>		<div> <div>21F. HOW DID INJURY OCCUR?</div> </div>	
<div> <div>22. I certify that (1) (this hospital) attended the deceased from June 14 19 66 to Sept. 29 19 66, that (1) (we) lost saw the deceased olive on Sept. 29 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</div> </div>					
<div> <div>23A. SIGNATURE</div> <div>Michael E. Pelczar</div> <div>M.D.</div> </div>				<div> <div>23B. DATE SIGNED</div> <div>9/29/66</div> </div>	
<div> <div>23C. PHYSICIAN'S NAME (Type)</div> <div>Michael E. Pelczar, SA Surgeon (R)</div> <div>M.D.</div> </div>				<div> <div>23D. ADDRESS</div> <div>US PHS Hospital, Balto, Md.</div> </div>	
<div> <div>24A. BURIAL CREMATION, REMOVAL (Specify)</div> <div>Removal</div> </div>		<div> <div>24B. DATE</div> <div>9/30/1966</div> </div>		<div> <div>24C. NAME of CEMETERY or CREMATORY</div> </div>	
<div> <div>24D. LOCATION (City, town, or county) (State)</div> <div>Dallas, Texas</div> </div>					
<div> <div>25A. DATE REC'D BY HEALTH DEPT.</div> <div>SEP 30 1966</div> </div>		<div> <div>25B. NAME OF REGISTRAR</div> <div>Robert E. Farkner</div> </div>		<div> <div>25C. FUNERAL DIRECTOR ADDRESS</div> <div>Wm. J. Fisher &amp; Sons Balto, Md. North Pa. ave.</div> </div>	

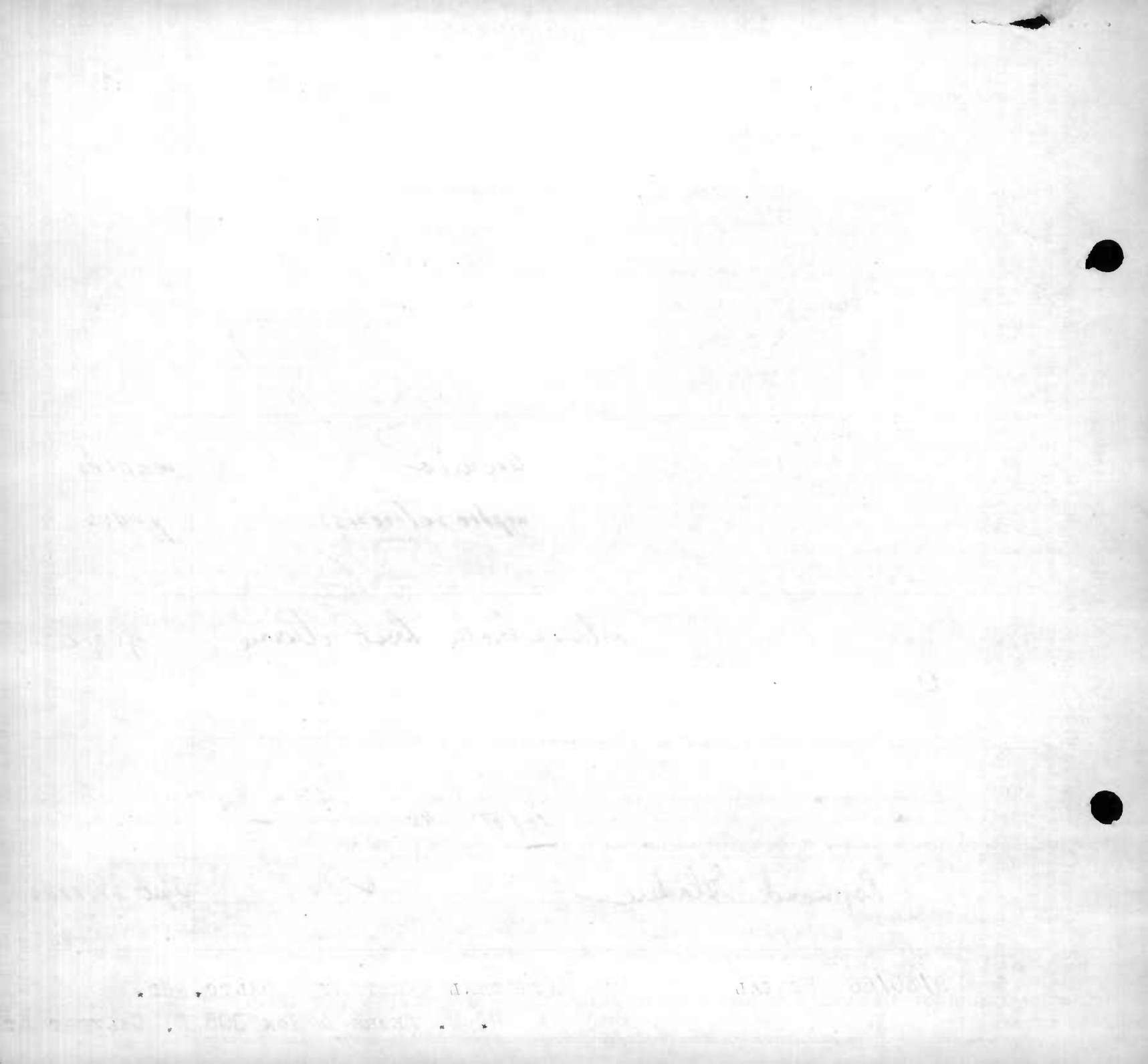




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

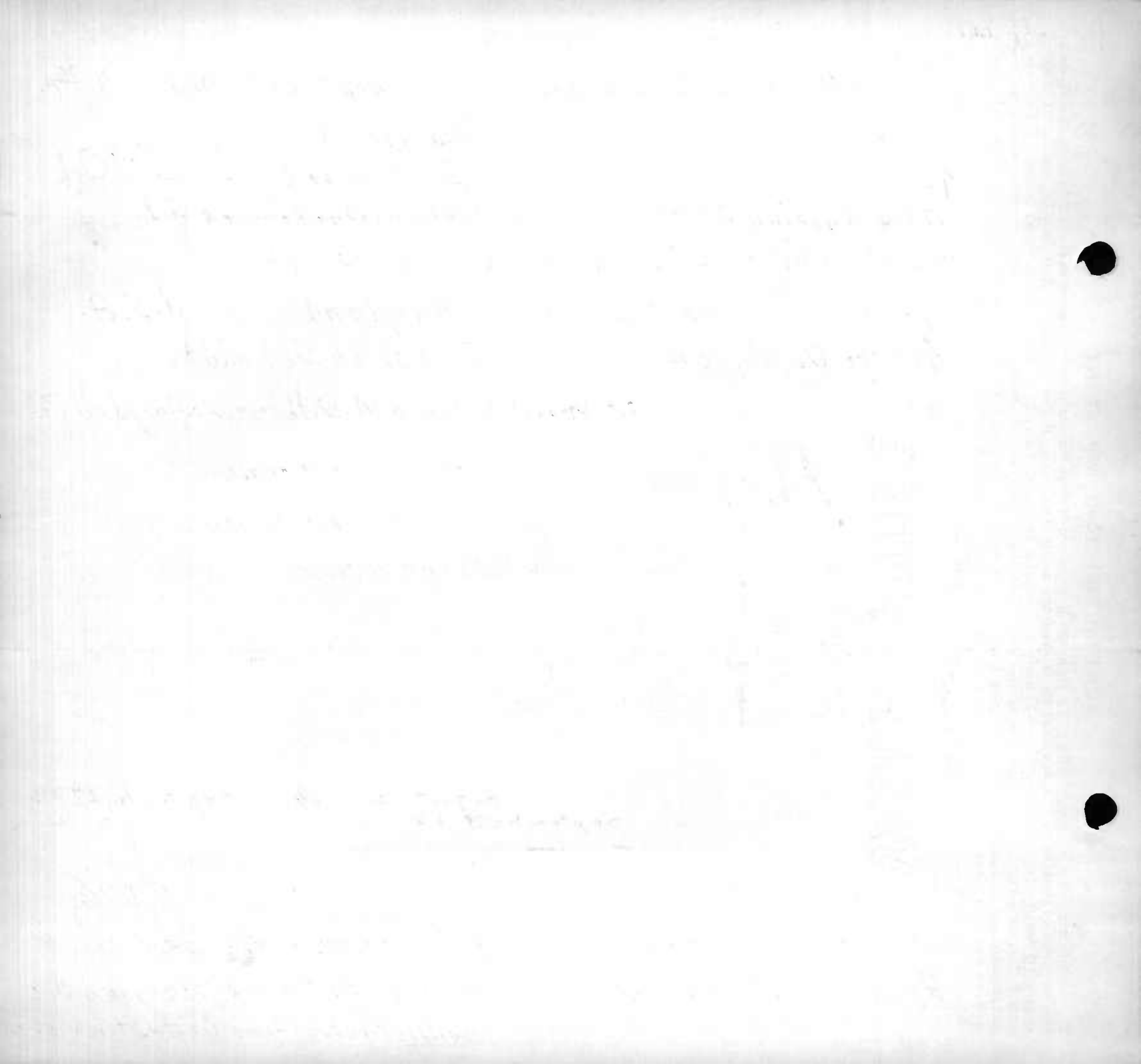
BIRTH NO. <b>66 09833</b>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b>		Registered No. <b>66 09833</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>DEMPSEY, Mrs Margaret Evans</b>			2. DATE AND HOUR OF DEATH <b>Sept. 27th - 1966 3:25 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JENKINS MEMORIAL HOSPITAL 1000 S. Caton Ave. Baltimore, Md. 21229</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>32 E. 26th St. 21218</b>		
5. SEX <b>F.</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Mar. 19, 1876</b>	9. AGE (In years lost birthday) <b>90</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>John Boulder Evans</b>			14. MOTHER'S MAIDEN NAME <b>Margaret O'Brien</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214 12 9679</b>	17. INFORMANT <b>MEDICAL RECORDS ROOM</b> ADDRESS		
18. <b>H46X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>nephrosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>years</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>colorectal cancer</b>			<b>years</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>December 10 1963</b> to <b>September 27 1966</b> , that (H) (we) last saw the deceased alive on <b>10/27 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Raymond Gladue</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>Sept 28, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>J Raymond Gladue</b>		23D. ADDRESS <b>Jenkins Memorial Hosp. 1000 Caton</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>9/30/66 BURIAL</b>		24B. DATE		24C. NAME of CEMETERY or CREMATORY <b>NEW CATHEDRAL CEMETERY BALTO. MD.</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 30 1966</b>			
25B. NAME OF REGISTRAR <b>Ed E. Talley, MD</b>		25C. FUNERAL DIRECTOR <b>H. W. MEARS &amp; SON 805 N. CALVERT ST.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09834</u>	
BIRTH NO. <u>66 09834</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Florence E. Marck</u>		2. DATE AND HOUR OF DEATH <u>Sept. 27, 1966</u> <u>7:30 P. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Hood Nursing Home</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>28-01</u>	
D. STREET ADDRESS (If rural, give location) <u>1904 W. Baltimore St.</u>		5. SEX <u>Female</u> 6. RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Divorced</u>	
8. DATE OF BIRTH <u>March 1, 1902</u> 9. AGE (in years last birthday) <u>64</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>Shirt Factory</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George D. Marck</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Schmidt</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-67-4668</u>	
17. INFORMANT <u>Narreen M. Withrow</u>		ADDRESS <u>320 Maryland Rd</u>			
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>Myocardial Infarction</u> DUE TO			
		(B) <u>Arterio Sclerotic Cardio</u> DUE TO			
		(C) <u>Unipolar Asystole</u>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>August 22</u> 19 <u>66</u> to <u>September 27</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>September 27</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>John H. Shaw</u>				23B. DATE SIGNED <u>9/27/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>John H. Shaw</u>				23D. ADDRESS <u>5501 Edmonson Ave. Kow. 28, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Sept 29, 1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. FUNERAL DIRECTOR <u>Walters Funeral Home</u>		24F. ADDRESS <u>1014 St. Lawrence St.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 30 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Walters Funeral Home</u>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09835</u>
BIRTH NO. <u>66 09835</u>		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>FREDERICK H. OWENS</u>		
2. DATE AND HOUR OF DEATH <u>Sept 27/66</u>		3. TIME <u>3:45 P.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>534 Chateau ave</u>		A, STATE <u>md.</u> B, COUNTY <u>Balto.</u>		
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Phoenix</u> <u>53-00</u>		
D. STREET ADDRESS (If rural, give location) <u>Blenheim Rd.</u>				
5. SEX <u>m</u>	6. RACE <u>negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 20, 1891</u>	9. AGE (In years last birthday) <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Jos. Owen</u>		
14. MOTHER'S MAIDEN NAME <u>Louisa Harris</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>115-32-2498</u>		17. INFORMANT <u>Jos. Owens-534 Chateau ave</u>		
18. <u>177X I</u>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Metastatic Carcinoma</u> <u>Prostate -</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>DUE TO</u>		
		(C) <u>DUE TO</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Bernard Kosto</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/28/66</u>
23C. PHYSICIAN'S NAME (Type) <u>BERNARD KOSTO</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/1/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. Zion</u>
24D. LOCATION (City, town, or county) (State) <u>Longview, Balto. Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 30 1966</u>		
25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>Wm. L. Chaturanga - 1701 Mt. Airy Rd. Balto. Md.</u>		

Metastatic carcinoma  
- metastatic -

ERWARD KOSTO  
Edward Kosto

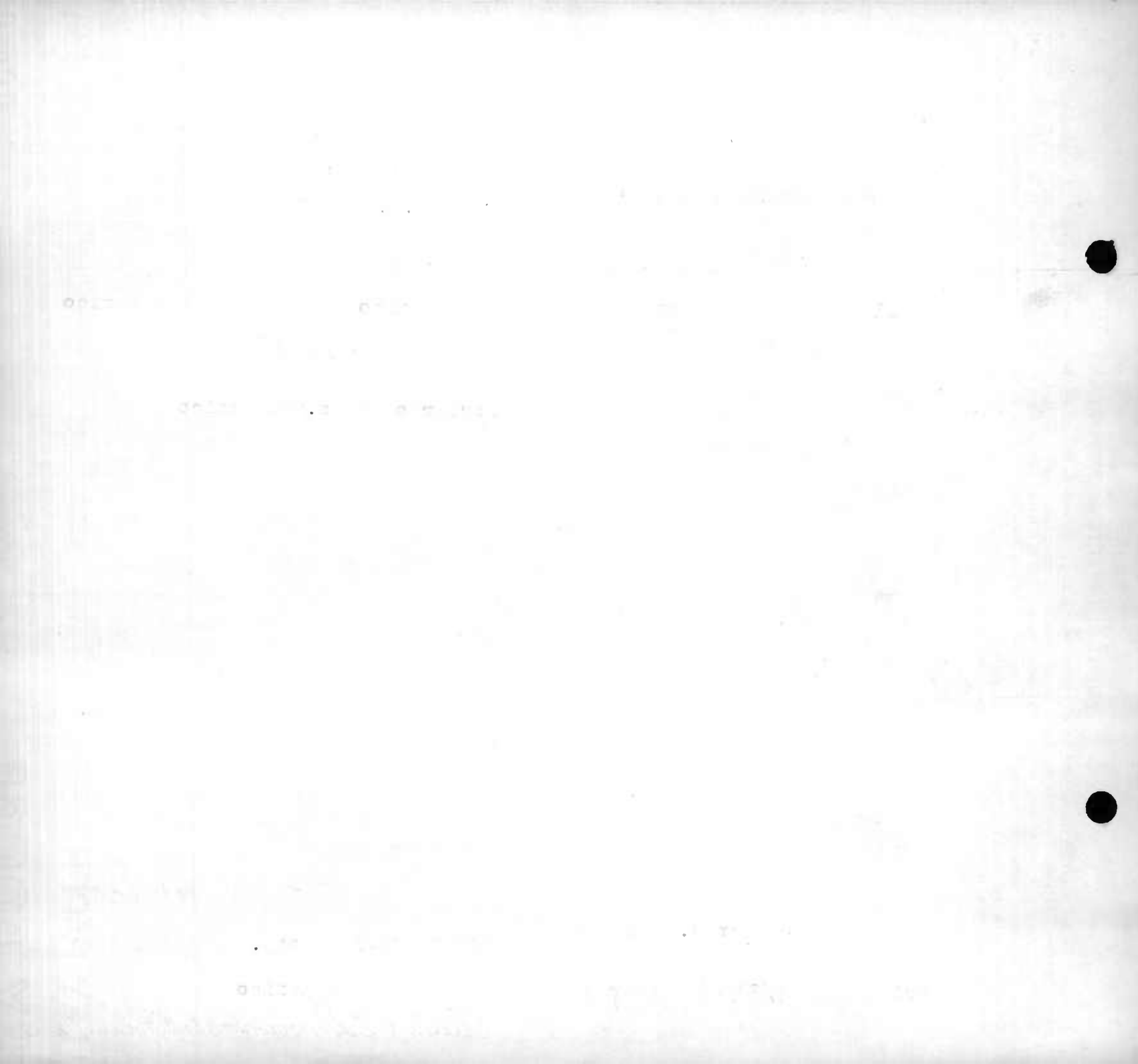
25th May 1961  
to 1/2/61

FUNERAL DIRECTOR: IMPORTANT

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<p><i>New Mexico</i>  <b>BIRTH NO.</b> 66/09836</p>		<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b>  <b>CERTIFICATE OF DEATH</b></p>		<p><b>Registered No.</b> 66 09836</p>							
<p><b>1. NAME OF DECEASED</b>                  (Type or Print) <b>PEA LOPEZ</b></p>			<p><b>2. DATE AND HOUR OF DEATH</b>                  11:42 pm 9-26-66 M.</p>								
<p><b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>33 JOHNS HOPKINS HOSPITAL</b></p>			<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)                  A. STATE <b>NEW MEXICO</b>                  B. COUNTY <b>Y-28</b>                  C. CITY OR TOWN (If outside city limits, write RURAL and give township)  <b>RODARTE,</b>                  D. STREET ADDRESS (If rural, give location)  <b>P.O. BOX 54</b></p>								
<p><b>5. SEX</b>  <b>MALE</b></p>	<p><b>6. RACE</b>  <b>WHITE</b></p>	<p><b>7. MARRIED, NEVER MARRIED</b>  <b>WIDOWED, DIVORCED (specify)</b>  <b>CHILD</b></p>	<p><b>8. DATE OF BIRTH</b>  <b>11-10-65</b></p>	<p><b>9. AGE</b> (In years lost birthday)  <b>10 MONTHS</b></p>	<p>If Under 1 Yr. Months Days                  If Under 24 Hrs. Hours Min.</p>						
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)  <b>Child</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b>  <b>none</b></p>	<p><b>11. BIRTHPLACE</b> (State or foreign country)  <b>New Mexico</b></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b>  <b>New Mexico</b></p>						
<p><b>13. FATHER'S NAME</b>  <b>PORFEREO LOPEZ</b></p>			<p><b>14. MOTHER'S MAIDEN NAME</b>  <b>GEBEVIEVE LOPEZ</b></p>								
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b>                  (Yes, no or unknown) (If yes, give war or dates of service)                  —</p>		<p><b>16. SOCIAL SECURITY NO.</b>                  —</p>	<p><b>17. INFORMANT ADDRESS</b>  <b>Porfereo Lopez, New Mexico</b></p>								
<p><b>18. CAUSE OF DEATH</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>502.1 I Respiratory Insufficiency</b></p> </td> <td style="width: 40%;"> <p><b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>3 40 hrs</b></p> </td> </tr> <tr> <td> <p><b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>41 hrs</b></p> </td> <td> <p><b>41 hrs</b></p> </td> </tr> <tr> <td colspan="2"> <p><b>II</b>                      OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  <b>subglottic tracheal stenosis, esophageal atresia, anular pancreas</b></p> </td> </tr> </table>						<p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>502.1 I Respiratory Insufficiency</b></p>	<p><b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>3 40 hrs</b></p>	<p><b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>41 hrs</b></p>	<p><b>41 hrs</b></p>	<p><b>II</b>                      OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  <b>subglottic tracheal stenosis, esophageal atresia, anular pancreas</b></p>	
<p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>502.1 I Respiratory Insufficiency</b></p>	<p><b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>3 40 hrs</b></p>										
<p><b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>41 hrs</b></p>	<p><b>41 hrs</b></p>										
<p><b>II</b>                      OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  <b>subglottic tracheal stenosis, esophageal atresia, anular pancreas</b></p>											
<p><b>19A. DATE OF OPERATION</b>  <b>4-18-66</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  <b>same as II</b></p>		<p><b>20A. AUTOPSY? (Yes or No)</b>  <b>pending YES</b></p>							
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)  <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)  <input type="checkbox"/></p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)  <input type="checkbox"/></p>							
<p><b>21D. TIME OF INJURY (APPROX.)</b>                  (Month) (Day) (Year) (Hour)</p>		<p><b>21E. INJURY OCCURRED</b>                  While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>							
<p><b>22. I certify that (I) (this hospital) attended the deceased from 9-1 1966 to 9-26 1966, that (I) (we) last saw the deceased alive on 9-26 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>											
<p><b>23A. SIGNATURE</b>  <i>Timothy J. Gardner, M.D.</i></p>				<p><b>23B. DATE SIGNED</b>  <b>9/26/66</b></p>							
<p><b>23C. PHYSICIAN'S NAME (Type)</b>  <b>TIMOTHY J. GARDNER M.D.</b></p>				<p><b>23D. ADDRESS</b>  <b>Johns Hopkins Hosp.</b></p>							
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b>  <b>Burial</b></p>		<p><b>24B. DATE</b>  <b>9/30/66</b></p>	<p><b>24C. NAME OF CEMETERY or CREMATORY</b>  <b>Rodarte</b></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State)  <b>New Mexico</b></p>						
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b>  <b>SEP 30 1966</b></p>		<p><b>25B. NAME OF REGISTRAR</b>  <i>Robert E. Taylor</i></p>		<p><b>25C. FUNERAL DIRECTOR ADDRESS</b>  <i>Austin E. Sorovan - 3818 Roland Ave</i></p>							

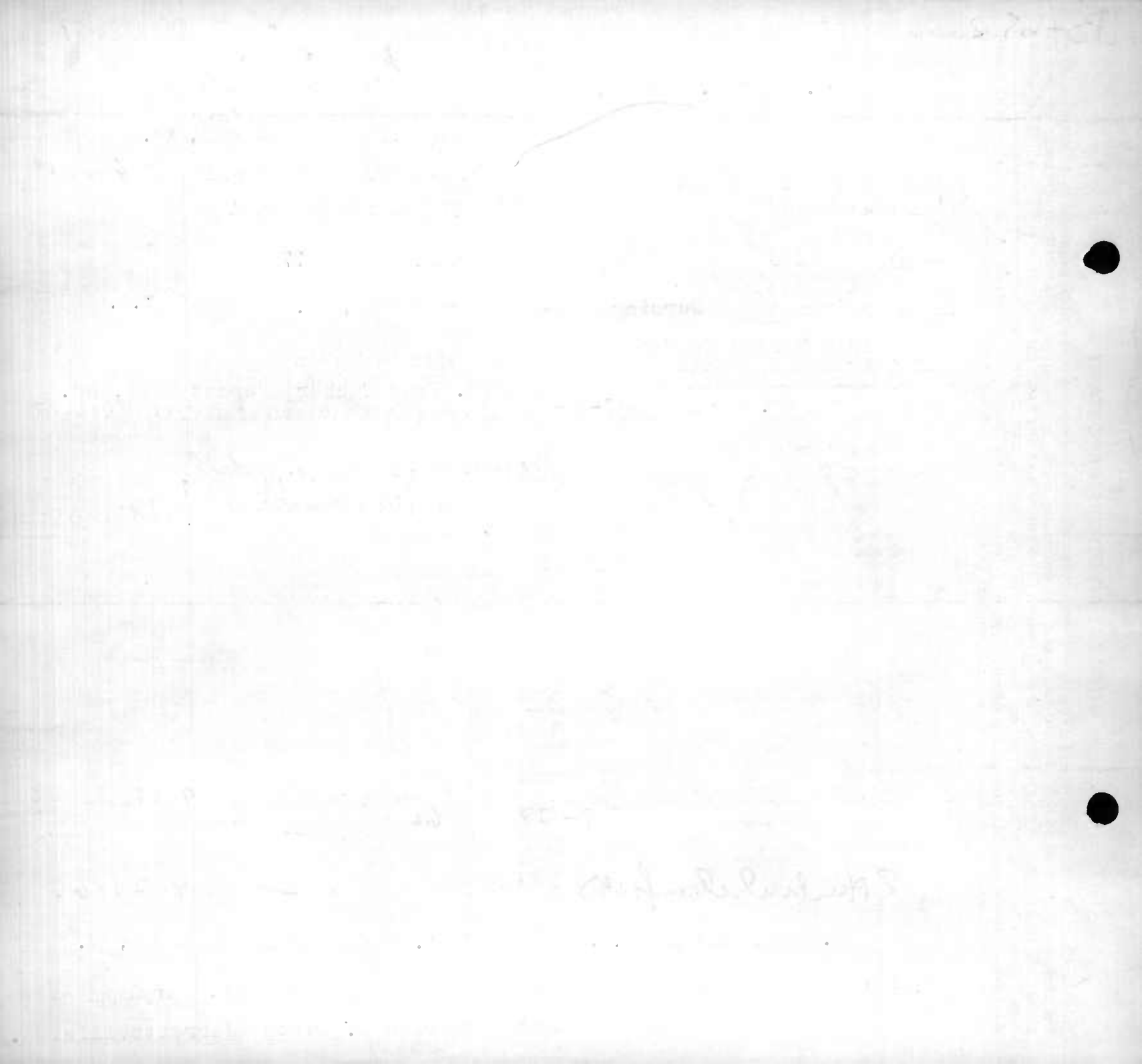




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09837				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 09837	
1. NAME OF DECEASED (Type or Print) Mrs. Ethel G. Bronson,				2. DATE AND HOUR OF DEATH 9/29/66 7:25 a.m.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 700 West 40th Street Keswick Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Harford C. CITY OR TOWN (If outside city limits, write RURAL and give township) XXXXXXX Forest Hill 62-00 D. STREET ADDRESS (If rural, give location) XXXXXXXXXXXXXXXXXXXX					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 10/12/1888	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse			10B. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Forest Hill, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Almiron Durand Grafton XXXXXXXXXXXXXXXXXXXX				14. MOTHER'S MAIDEN NAME Elizabeth Kean					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Yes W. War 1		16. SOCIAL SECURITY NO. 081-20-2822		17. INFORMANT Mrs. Fred Tucker Mary E. Tucker R.D. 700 W 40th St			ADDRESS Forest Hill, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) He had a carcinoma, probably from the stomach (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH 18 mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 9-29 1966 that (I) (we) last saw the deceased alive on 9-29 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE E. Hunter Wilson M.D.				23B. DATE SIGNED 9-29-66			23C. PHYSICIAN'S NAME (Type) E. Hunter Wilson M.D.		
23D. ADDRESS 2 St. Martins Lane Baltimore, Md.				24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE 10/1/1966		24C. NAME OF CEMETERY or CREMATORY Rock Spring		24D. LOCATION (City, town, or county) (State) Forest Hill, Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 30 1966		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Charles E. Kurtz Jarrettsville, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 09838		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09838	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>McCray, James</i>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH <i>9-29-66</i> <i>7:05 A. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
<b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i> <i>33 Brady St</i>		A. STATE <i>Maryland</i>			
		B. COUNTY			
5. SEX <i>Male</i>		6. RACE <i>Negro</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	
8. DATE OF BIRTH <i>12/24/11</i>		9. AGE (In years last birthday) <i>54</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steel worker</i>	
11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Henry McCray</i>	
14. MOTHER'S MAIDEN NAME <i>Allama Stanton</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>244-45-3931</i>	
17. INFORMANT <i>Lillian McCray</i>		ADDRESS <i>420 E. North Ave.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cut Cell Carcinoma of the lung</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>2 mo.</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>9-28-66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9-28-66</i> to <i>9-29-66</i> , that (I) (we) last saw the deceased alive on <i>9-29-66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David J. Mishelevich</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> Intern <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9-29-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>David J. Mishelevich</i>		23D. ADDRESS <i>Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal Burial</i>		24B. DATE <i>10-2-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>HAWKINS CHAPEL</i>	
24D. LOCATION (City, town, or county) (State) <i>FRANKLINTON, NORTH CAROLINA</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 30 1966</i>			
25B. NAME OF REGISTRAR <i>Paul E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>MARSHALL W. BOWEN, JR. 1735 HARTFORD AVE.</i>			

Letter from J.H.H.

10-6-66

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09839</b>	
BIRTH NO. <b>66 09839</b>		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>DeCosmo Fiore</b>		<b>9-28-66 7:11 P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sina Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3412 Fairview Avenue</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>5-16-1916</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>50</b>
13. FATHER'S NAME <b>Fiore A. DeCosmo</b>		11. BIRTHPLACE (State or foreign country) <b>Old Forge, Pa.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 2</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO. <b>176-16-6823</b>		14. MOTHER'S MAIDEN NAME <b>DiNardo</b>	
17. INFORMANT <b>Marie A. DeCosmo</b>		ADDRESS <b>3412 Fairview Avenue</b>	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Agute Myocardial Infarction</b>		<b>2 hrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Ischemic Heart Disease</b>		<b>over 6 yrs</b>	
<b>Hypercholesterolemia</b>		<b>over 10 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		20A. AUTOPSY? (Yes or No)	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 1966 to May 28th 1966</b> , that (I) (we) last saw the deceased alive on <b>5-28-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>George M. Ramaphram</b> M.D.		23B. DATE SIGNED <b>9-28-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>George M. Ramaphram</b> M.D.		23D. ADDRESS <b>3502 Gaydon Rd Baltimore 7, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-3-66</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 30 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>Ellsworth Amacost</b>		ADDRESS <b>4600 Liberty Hghts.</b>	





FUNERAL DIRECTOR: IMPORTANT

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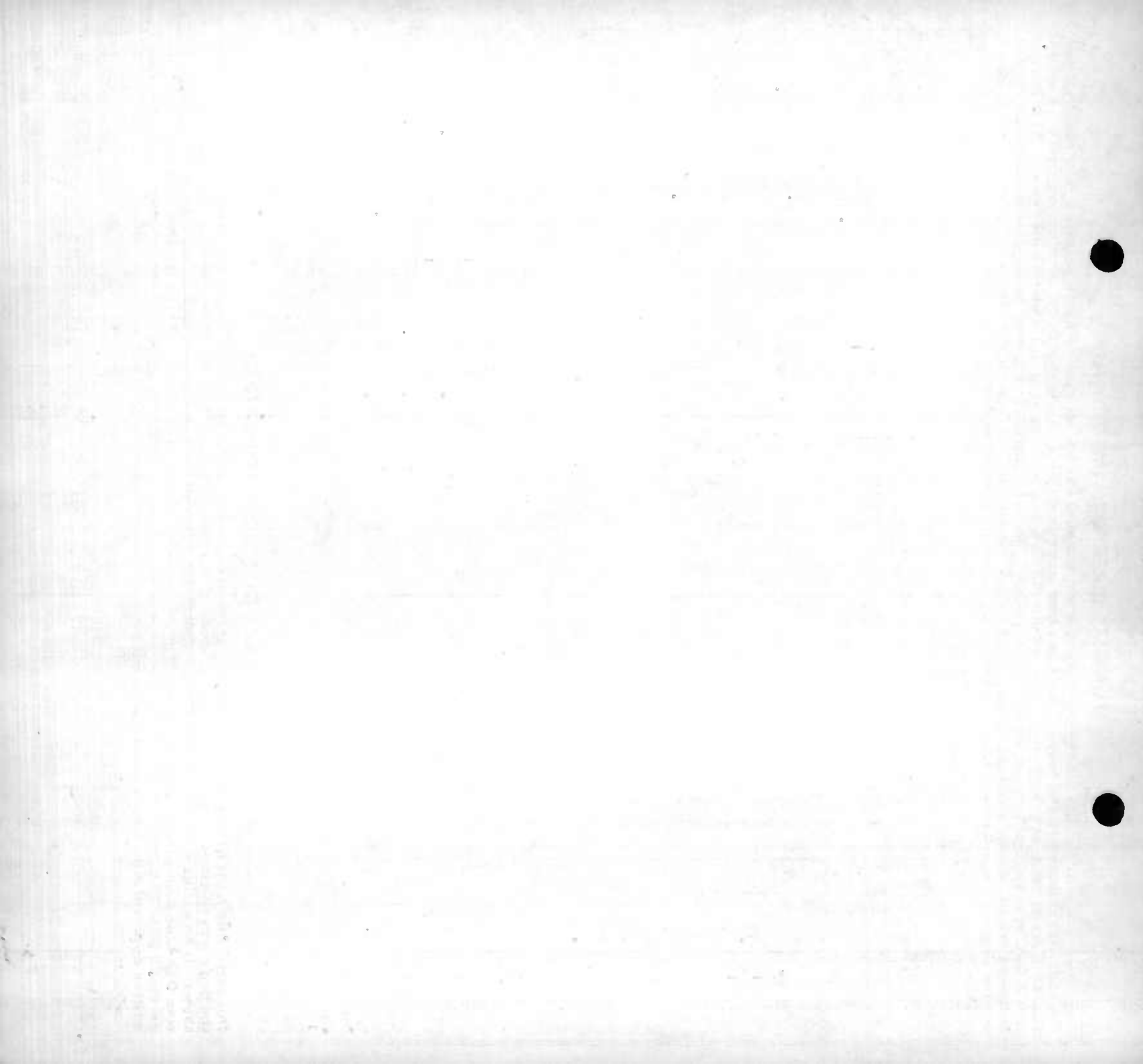
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09840</b>	
BIRTH NO. <b>66 3840</b>		<b>CERTIFICATE OF DEATH</b>		DATE AND HOUR OF DEATH <b>11:50AM</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Alverta Ray</b>		2. DATE AND HOUR OF DEATH <b>Sept. 28, 1966 11:50 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>10-02</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 The Johns Hopkins Hospital</b>		D. STREET ADDRESS (If rural, give location) <b>1239 East Eager St.</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>4/23/10</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTO., MD.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Eugene</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Harris</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Geraldene Richardson</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>381X I Intracerebral blood</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>9/28</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intracerebral Catastrophe</b>		19C. AUTOPSY? (Yes or No) <b>yes</b>	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. TIME OF INJURY (APPROX.)		21B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/28</b> to <b>9/28</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/28</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. Stan Wilson</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9/28/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>W Stan Wilson</b>		M.D. ADDRESS <b>JWH.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/3/66</b>	24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 30 1966</b>		25B. NAME OF REGISTRAR <b>Philip E. Taylor</b>		25C. FUNERAL DIRECTOR <b>WM C. MARCH</b>	
				ADDRESS <b>928 E. North Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09841</b>	
<b>BIRTH-NO.</b> <b>02060 09841</b> <b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Ida E. Cook</b>				<b>2. DATE AND HOUR OF DEATH</b> <b>September 25 1966</b> M.	
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>Marylander Apts.</b> <b>3501 St. Paul St.</b> <b>Apt. 607</b>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>Md.</b> <b>B. COUNTY</b> <b>12-02</b> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>Baltimore</b> <b>D. STREET ADDRESS</b> (If rural, give location) <b>3501 St. Paul St. Apt 607</b>	
<b>5. SEX</b> <b>F</b>	<b>6. RACE</b> <b>Wh</b>	<b>7. MARRIED, NEVER MARRIED</b> <b>WIDOWED, DIVORCED (specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>9-29-76</b>	<b>9. AGE (in years last birthday)</b> <b>89</b>	<b>If Under 1 Yr. Months Days</b> <b>If Under 24 Hrs. Hours Min.</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>	
<b>13. FATHER'S NAME</b> <b>Late-Robert D'Unger</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Katherine</b>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>ADDRESS</b> <b>Mr. E. H. D'Unger</b> <b>11356 Gladwin St., Los Angeles, Calif</b>	
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 yr +</b>				<b>18. CAUSE OF DEATH</b> <b>(A) Anteroseptal myocardial infarction</b> <b>(B) DUE TO</b> <b>(C) DUE TO</b>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from January 10 19 51 to Sept 25 19 66, that (I) (we) last saw the deceased alive on Sept 25 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>John A. Nesbitt, Jr.</b> M.D.				<b>23B. DATE SIGNED</b> <b>9-26-66</b>	
<b>23C. PHYSICIAN'S NAME (Type)</b>				<b>23D. ADDRESS</b>	
<b>John A. Nesbitt, Jr.</b> M.D.				<b>1009 Frederick Rd. Balt. 21228</b>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Entombment</b>		<b>24B. DATE</b> <b>10-1-66</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Lorraine Park Mausoleum - Baltimore, Md.</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>SEP 30 1966</b>		<b>25B. NAME OF REGISTRAR</b> <b>John E. Taylor</b>		<b>25C. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <b>Witzke F.D. - 4101 Edmondson Av.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>3650</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09842</b>	
M.E. CASE NO. <b>66 09842</b>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Bertha Marie Brown</b>			2. DATE AND HOUR OF DEATH <b>Sept. 27, 1966</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Ventnor Lodge</b> <b>90 526 S. Chapelgate Lane</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balt</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore Catonsville</b> D. STREET ADDRESS (If rural, give location) <b>69 Garden Ridge Rd.</b>		
5. SEX <b>F</b>	6. RACE <b>Wh</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>9-11-81</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Late -- Zimmer</b>			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. George Gifford</b>		ADDRESS <b>69 Garden Ridge Rd. -28</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>150.01</b> <b>Supremacy of Age</b> <b>Generalized Arteriosclerosis</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 19 63</b> to <b>Sept 28 19 66</b> , that (I) (we) last saw the deceased alive on <b>Sept 27 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. Thomas E. Abbott</b> M.D.			23B. DATE SIGNED <b>9-28-66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Thomas E. Abbott</b> M.D.			23D. ADDRESS <b>4509 Liberty Heights</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-30-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cem.</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 30 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Witzke F.D. -4101 Edmondson Av.</b>	

Information of age  
How school children

1845

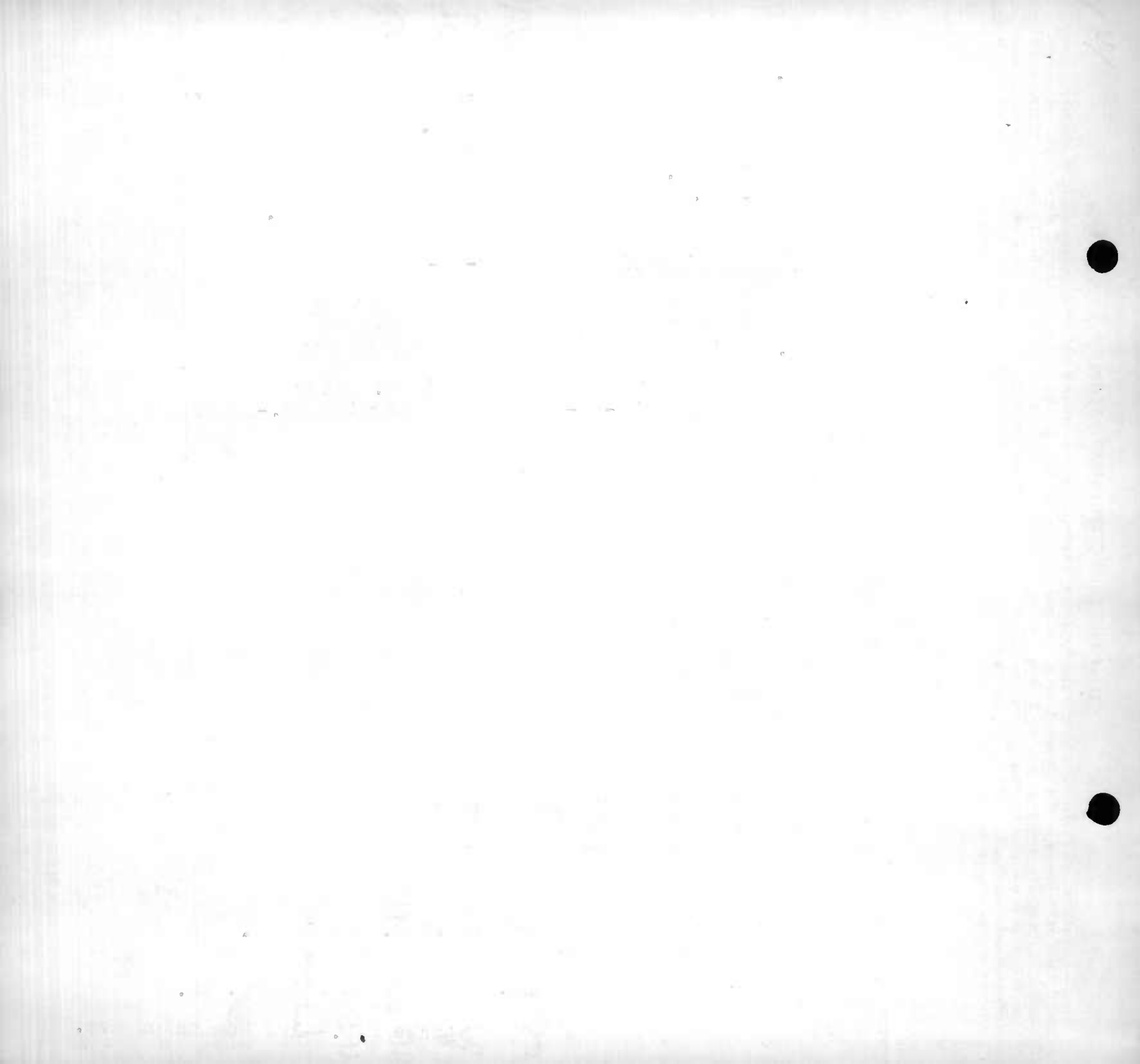
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 09843	
BIRTH NO. 66 09843		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Inez Reese		2. DATE AND HOUR OF DEATH Sept 26, 1966 8:40 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6205 Wallis Ave. Baltimore, Md.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-20 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6205 Wallis Ave.			
5. SEX F	6. RACE Wh	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 5-23-84	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George H. Davis				14. MOTHER'S MAIDEN NAME Adaline Lily			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-05-0470A		17. INFORMANT Sadie E. Reier		ADDRESS 506 Chadwick Rd.-Lutherville	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO Broncho pneumonia		INTERVAL BETWEEN ONSET AND DEATH Days	
				(B) DUE TO Cerebral Vascular Accident			
				(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 19 60 to Sept 19 66, that (I) (we) last saw the deceased alive on Sept 24 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Francis Daly				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Sept 26 1966	
23C. PHYSICIAN'S NAME (Type) Francis Daly		23D. ADDRESS 3201 N. Charles St.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-29-66		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 30 1966		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Witzke F.D.		ADDRESS -4101 Edmondson Ave.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09844				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09844	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>FERGUSON, NANCY BEATRICE</b>				2. DATE AND HOUR OF DEATH <b>Sep. 28, 1966 4 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>44 Union Memorial Hosp. Baltimore, Md.</b>				A. STATE <b>Maryland</b> B. COUNTY <b>12-03</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 18</b>			
				D. STREET ADDRESS (If rural, give location) <b>2800 N. Calvert Street</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>01-26-82</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H S W F</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>
13. FATHER'S NAME <b>RICHARD PUGH</b>			14. MOTHER'S MAIDEN NAME <b>ANNA Unknown</b>				
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>220-30-5307-A</b>		17. INFORMANT ADDRESS <b>Mrs. Thomas Mohr 6164 Regent Park Drive</b>		
18. <b>792X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO (B) DUE TO (C) <b>Pneumonitis, C.H.F.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sep. 8 1966</b> to <b>Sep. 28 1966</b> , that (I) (we) last saw the deceased alive on <b>Sep. 28 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Sun young Choi</b> M.D.				23B. DATE SIGNED <b>Sep 28, 66</b>		23C. PHYSICIAN'S NAME (Type) <b>DR. SANG WON SONG</b> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-1-66</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 30 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Witzke F.D.</b>		25D. ADDRESS <b>-4101 Edmondson Av.</b>	

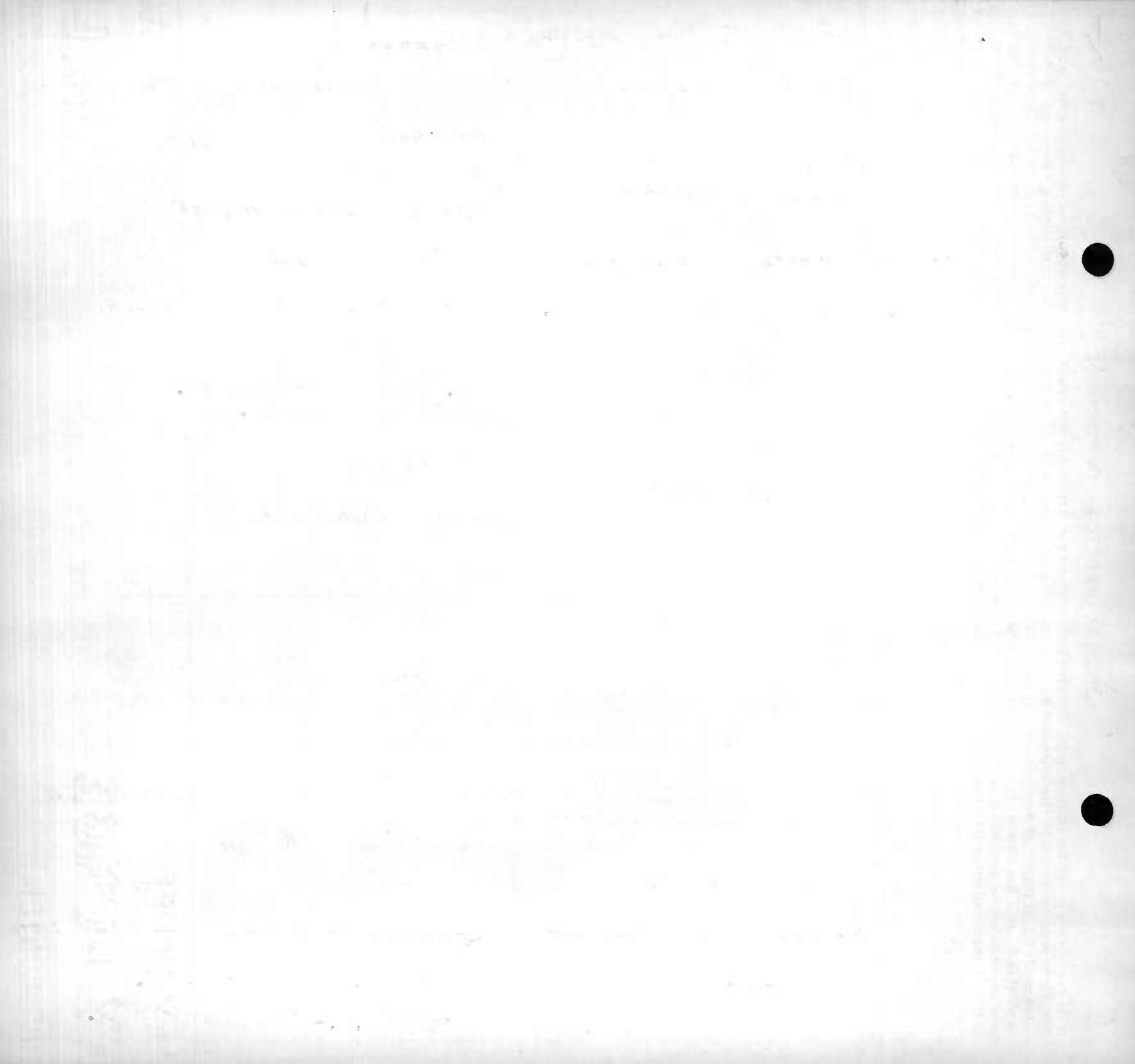
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U. S. AIR FORCE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

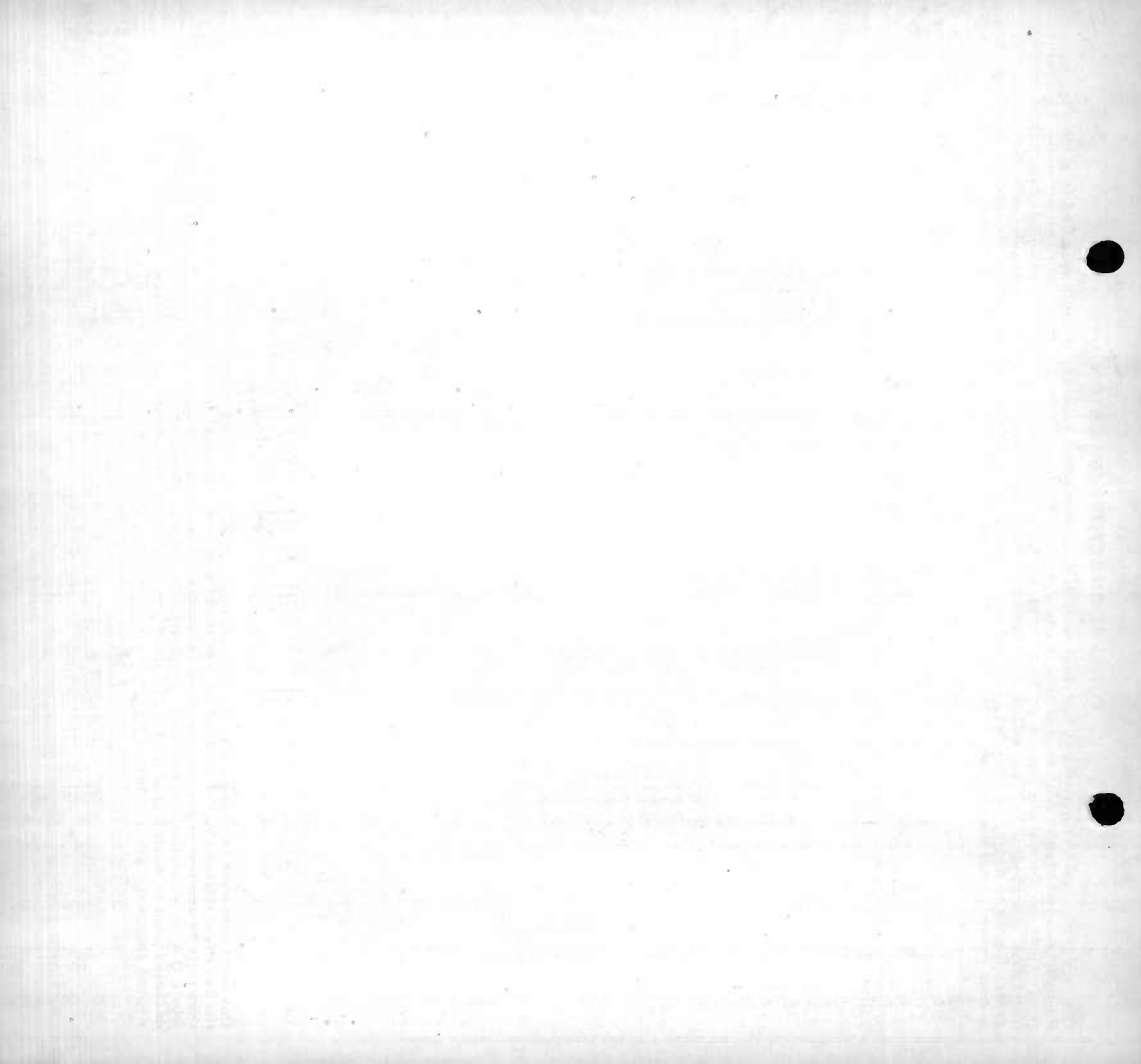
BIRTH NO. <b>66 09845</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09845</b>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MARY A. CONNERAN</b>			2. DATE AND HOUR OF DEATH <b>SEPTEMBER 26, 1966 10 53 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Lutheran Hospital of Maryland Baltimore, Md. 21216</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>16-08</b>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			D. STREET ADDRESS (If rural, give location) <b>3718 EDMONDSON AVENUE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>12/31/93</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Lutheran Hosp.</b>	11. BIRTHPLACE (State or foreign country) <b>U. S. A. - Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>J. Joseph Conneran, Jr.</b> <b>3718 Edmondson Av.</b>		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PERITONITIS</b>			CAUSE OF DEATH (A) DUE TO <b>Ruptured Diverticulitis</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		(C)
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>September 25 1966</b> to <b>September 28 1966</b> , that (I) (we) last saw the deceased alive on <b>September 26 1966</b> and that in (my) (our) opinion death occurred on the date <b>10-25 AM</b> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Manuel G. Fontanilla</b>			23B. DATE SIGNED <b>9/26/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>MANUEL G. FONTANILLA M.D.</b>			23D. ADDRESS <b>LUTHERAN HOSPITAL OF MD. 21216</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-30-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem. Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 30 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Falek, M.D.</b>		25C. FUNERAL DIRECTOR <b>Witzke F.D.-4101 Edmondson Av.</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 09846		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09846	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Amos L. Buchsbaum			2. DATE AND HOUR OF DEATH Sept. 26, 1966 10:45 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 729 Charing Cross Rd. Baltimore, 29, Md.			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00		
D. STREET ADDRESS (If rural, give location) 729 Charing Cross Rd.					
5. SEX M	6. RACE Wh	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 5-28-93	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Cashier		10B. KIND OF BUSINESS OR INDUSTRY John Hancock Ins. Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Late-Theodore Buchsbaum			14. MOTHER'S MAIDEN NAME Late-Mary Wohner		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-01-3939		17. INFORMANT Mr. Charles E. Quaty 4506 Old Fred'k. Rd. - Apt. C	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(A) DUE TO Coronary artery sclerosis + Myocardial Insufficiency (B) DUE TO Arteriosclerotic Cardiovascular Disease (C)		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 1, 1966 to Sept. 26, 1966, that (I) (we) last saw the deceased alive on Sept 26, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry L. Knipp				23B. DATE SIGNED 9-28-66	
23C. PHYSICIAN'S NAME (Type) Harry Knipp				23D. ADDRESS 4116 Edmondson Ave. Balt 29 Ind.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-29-66		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cem.	
24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 30 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Witzke F.D.-4101 Edmondson Ave.	
25D. ADDRESS					



47-75-26  
JJ

66 09847

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 66 09847

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GROSS, MARGARET (JOHNSON)

2. DATE AND HOUR OF DEATH

9/26/66

10<sup>20</sup> P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)BALTIMORE CITY HOSPITALS  
4940 EASTERN AVE  
BALT, MD. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

139 W. HAMBURG #21230

5. SEX

F

6. RACE

N

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (Specify)

COMMON LAW

8. DATE OF BIRTH

12-7-21

9. AGE (In years  
last birthday)

44

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Clothes Pressor

10B. KIND OF BUSINESS OR INDUSTRY

-Laundress

11. BIRTHPLACE (State or foreign country)

BALT. MD.

12. CITIZEN OF  
WHAT COUNTRY?

USA.

13. FATHER'S NAME

HERMAN SIDNEY

14. MOTHER'S MAIDEN NAME

GROSS, Pauline

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 EASTERN AVE. #21224

18. 17501

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Ascites, Wgt ↓, ANEMIA, EDEMA  
DUE TO ? Ovarian Ca ? END STAGE cirrhosis

4 mth

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTAINING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/20 19 66 to 9/26 19 66.  
that (I) (we) lost saw the deceased alive on 9/26/66 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard Maffezzoli

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

9/26/66

23C. PHYSICIAN'S  
NAME (Type)

RICHARD MAFFEZZOLI

M.D.

23D. ADDRESS

BALTIMORE CITY HOSPITAL  
4940 EASTERN AVE. - BALT. MD.24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

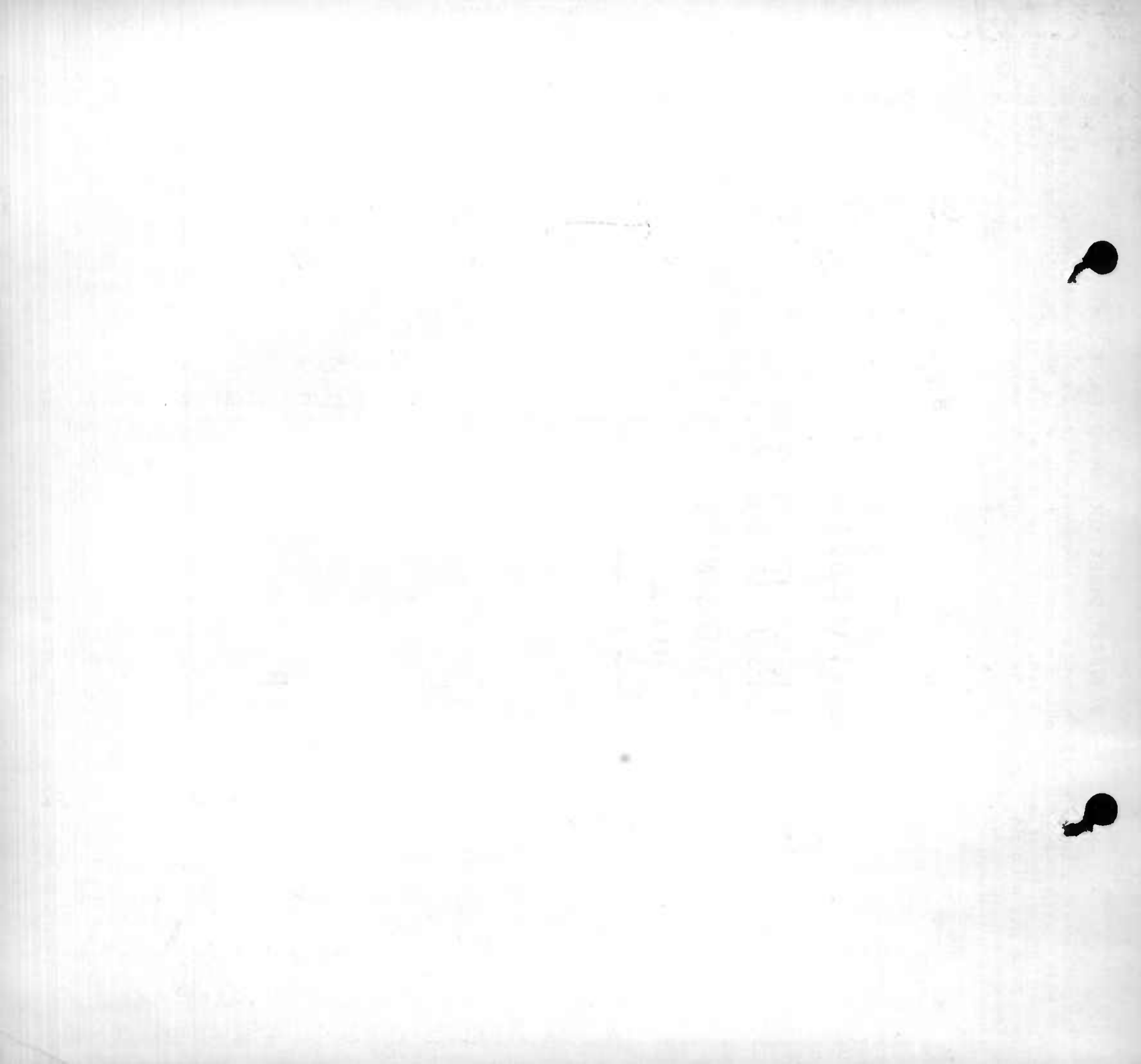
25C. FUNERAL DIRECTOR

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09848		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09848	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Mr John Murray			2. DATE AND HOUR OF DEATH 9/27/66 1232 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY 318 E 26th St Balt Md		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 318 E 26th St 12-03		
5. SEX MALE	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 7/12/12	9. AGE (In years last birthday) 54	10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Disability Retired	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? American
13. FATHER'S NAME John Youngblood			14. MOTHER'S MAIDEN NAME Georgianna Murray		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) yes, give year or dates of service		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS MRS. ANNA HUGHES (Cousin) same address		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bilateral Bronchopneumonia (acc. to med. examiner's directive)			INTERVAL BETWEEN ONSET AND DEATH 7 wks.		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from September 27, 19 66 to September 27, 19 66, that (I) (we) lost saw the deceased alive on September 27, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James W. Carty, Jr.			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/27/66
23C. PHYSICIAN'S NAME (Type) JAMES W. CARTY, JR.			23D. ADDRESS THE UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10-1-66	24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem Balto		24D. LOCATION (City, town, or county) (State) Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 30 1966		25B. NAME OF REGISTRAR R. B. E. Fisher, M.D.	25C. FUNERAL DIRECTOR ADDRESS Rayner Sanders 217 E Preston St		

11/2/22

11/2/22

3183-26th St. N.W.

3183-26th St. N.W.

3183-26th St. N.W.

3183-26th St. N.W.

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3183-26th St. N.W.

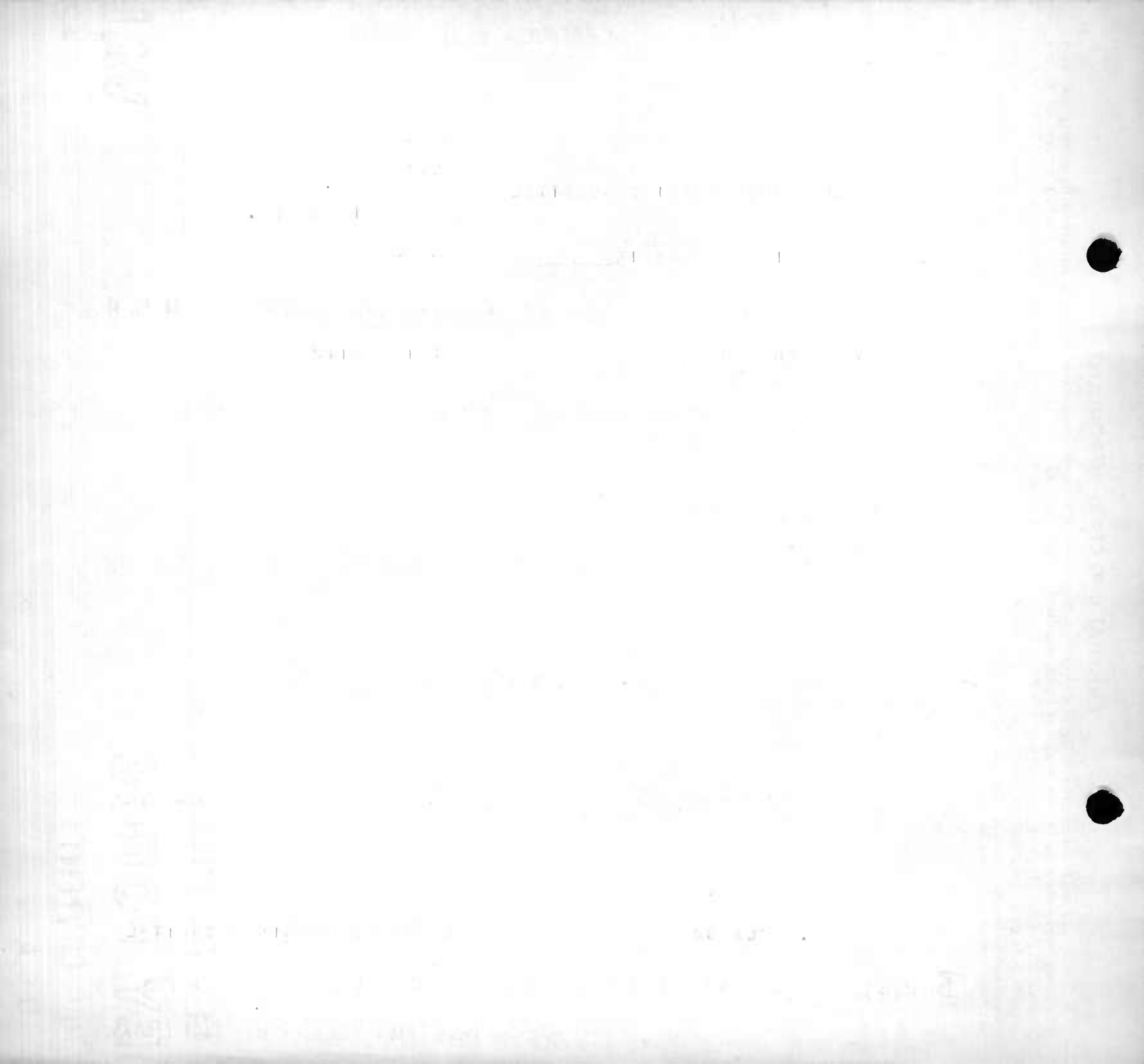
3183-26th St. N.W.

3183-26th St. N.W.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09849</u>	
BIRTH NO. <u>66 09849</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>LEVEN JOHNSON</u>		2. DATE AND HOUR OF DEATH <u>September 26<sup>th</sup> 1966</u> <u>4:40 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>2304 MADISON AVE.</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGROID</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>6-22-05</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self. Employed.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>EASTERN Shore, VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>BURTON JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>LOTTIE SMITH</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>JULIA JOHNSON 2304 Madison Ave.</u>	
18. <u>1977 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>DISSEMINATED CARCINOMATOSIS</u> DUE TO (B) <u>CARCINOMA OF PROSTATE GLAND.</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>8-29-1966</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CARCINOMA OF PROSTATE</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>August 22<sup>nd</sup> 1966</u> to <u>September 26<sup>th</sup> 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept. 26<sup>th</sup> 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>We did.</u>					
23A. SIGNATURE <u>F. Velasco</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-26-1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>F. VELASCO</u>		23D. ADDRESS M.D. <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-30-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem PK. Balto. Md.</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 30 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>MORTON &amp; DYETT F.H.</u>	
				ADDRESS <u>1701 LAURENS</u>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09850</b>	
66 09850 CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>ANNA K. SCHLOER</b>			2. DATE AND HOUR OF DEATH <b>Sept. 29, 1966</b> <b>9:15 pm</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>00</b> <b>3033 Northern Parkway</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>27-05</b> <b>3033 Northern Parkway</b>		
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>Nov. 1, 1890</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Charles Miller</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Gruner</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-05-72040</b>		17. INFORMANT ADDRESS <b>Mr. James C. Miller 3033 Northern Parkway</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>422.1 I</b> <b>Cerebral Thrombosis</b> DUE TO <b>Arteriosclerotic cardio-vascular disease</b> DUE TO <b>5 years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 3, 1961</b> to <b>September 29, 1966</b> , that (I) (we) last saw the deceased alive on <b>September 29, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. Alessi</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>9/30/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Edward J. Alessi</b>				23D. ADDRESS <b>6217 Harford Road, Balto., Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>10/3/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>SEP 30 1966 R. L. E. F. J. J.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. - 5305 Harford Rd. - 14</b>			







WATLEY POLICE

43-01-90 IB

5-25 66 09852

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 66 09852

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>John J. Sanzone</i>		2. DATE AND HOUR OF DEATH <i>30 Sept 1966 5:00 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hospitals</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY	
C. CITY OR TOWN <i>Baltimore</i>		(If outside city limits, write RURAL and give township)		D. STREET ADDRESS <i>4112 Granite Ave</i>		21206	
5. SEX <i>M</i>	6. RACE <i>Caucasian</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>10-15-25</i>	9. AGE (In years last birthday) <i>51</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck driver</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Baltimore City</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Vincent Sanzone</i>				14. MOTHER'S MAIDEN NAME <i>Groce Tumminello</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW 2</i>		16. SOCIAL SECURITY NO. <i>218-01-1339</i>		17. INFORMANT <i>Baltimore, Md. 21224</i>			
18. <i>433.01</i>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO <i>Cardiac Arrest</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10-15 min</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <i>Brain Damage</i>		<i>13 day</i>	
				(C) <i>Cardiac Arrest</i>		<i>13 day</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <i>17 Sept 19 66</i> to <i>30 Sept 19 66</i> , that (H) (we) last saw the deceased alive on <i>30 Sept 19 66</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Dudley A. Raine, Jr.</i> M.D.				23B. DATE SIGNED <i>30 Sept 1966</i>			
23C. PHYSICIAN'S NAME (Type) <i>Dr. Dudley A. Raine, Jr.</i> M.D.		23D. ADDRESS <i>BCH-4940 Eastern Avenue, Baltimore, Md</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/4/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore National Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 30 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md.</i>		ADDRESS <i>21214</i>	

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]*

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09853</b>
BIRTH NO. <b>66 09853</b>		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Harris, Thaddeus Nease</b>		
2. DATE AND HOUR OF DEATH <b>9/28/66 1:05 A.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <b>MD.</b> B. COUNTY <b>BALT.</b>		
<b>42 SINAI HOSPITAL OF BALTIMORE INC.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 53-00</b>		
D. STREET ADDRESS (If rural, give location) <b>7902 Aiken Ave.</b>				
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>10/22/10</b>	9. AGE (In years lost birthday) <b>55</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Photographic Supv.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Martin Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Harris</b>		
14. MOTHER'S MAIDEN NAME <b>Sina Mackay</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>256-12-2220</b>		17. INFORMANT ADDRESS <b>Mrs. Evelyn Harris (Same)</b>
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH		
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Acute Myocardial Infarction</b>		
18B. ANTECEDENT CAUSES		(B) <b>ASCD</b>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		
18C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <b>9/28/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>9/27/1966</b> to <b>9/28/1966</b> , that (I) (we) last saw the deceased alive on <b>9/28/1966</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Hyman Greenfield</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/28/66</b>
23C. PHYSICIAN'S NAME (Type) <b>HYMAN GREENFIELD</b>		23D. ADDRESS <b>SINAI HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/1/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 30 1966</b>	25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Balto. Md. 21214</b>		

2. a. and b. in the same way as in the first case. The first case is the case of a simple function, and the second case is the case of a function of a function.

3. a. and b. in the same way as in the first case. The first case is the case of a simple function, and the second case is the case of a function of a function.

4. a. and b. in the same way as in the first case. The first case is the case of a simple function, and the second case is the case of a function of a function.

5. a. and b. in the same way as in the first case. The first case is the case of a simple function, and the second case is the case of a function of a function.

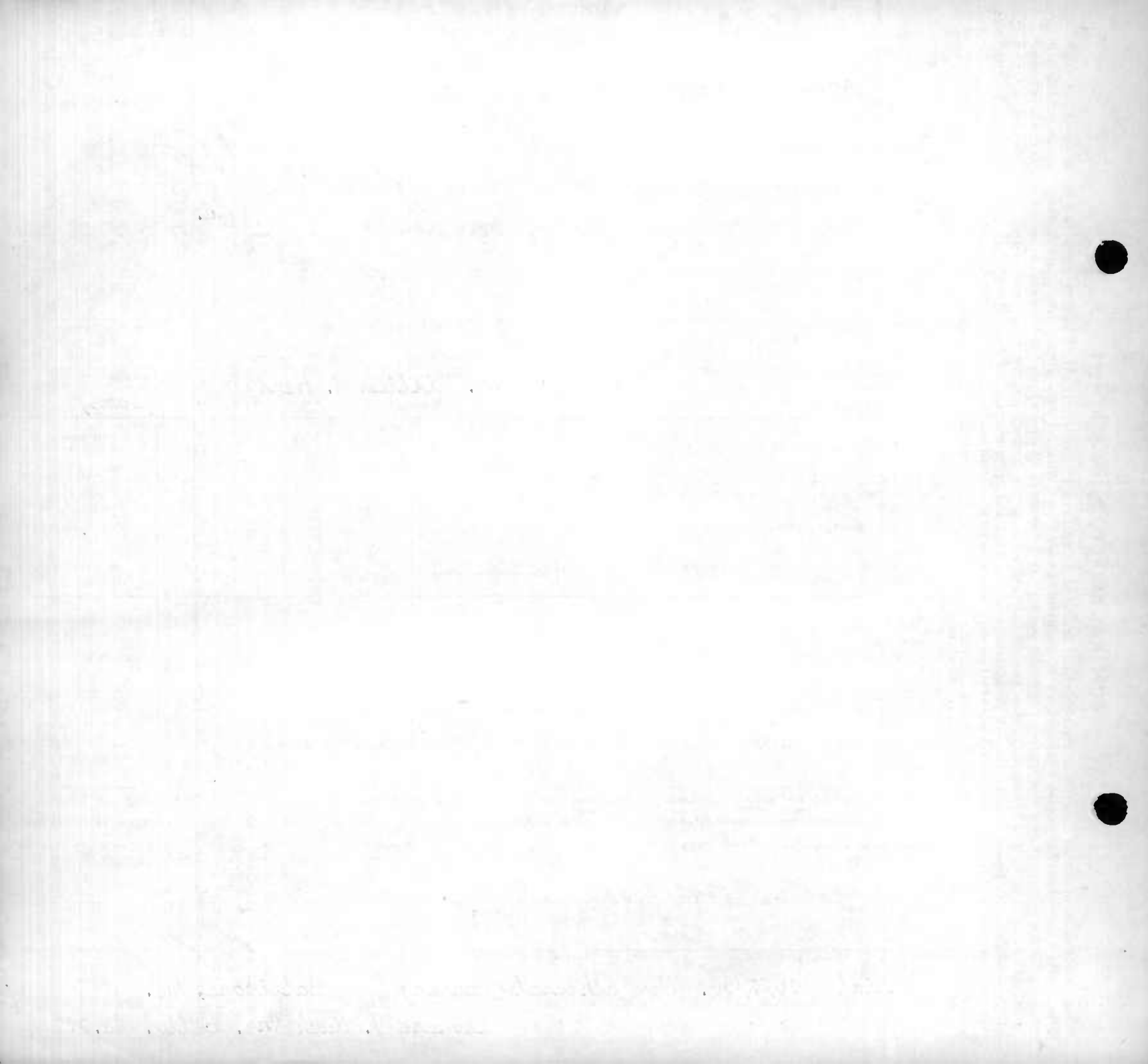
6. a. and b. in the same way as in the first case. The first case is the case of a simple function, and the second case is the case of a function of a function.

7. a. and b. in the same way as in the first case. The first case is the case of a simple function, and the second case is the case of a function of a function.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09854</u>	
BIRTH NO. <u>66 09854</u>				<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.				DATE AND HOUR OF DEATH <u>9/28/66</u> <u>7:15 A.M.</u>	
1. NAME OF DECEASED (Type or Print) <u>MAV S. HENRY</u>					
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u> <u>48</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> #12 <u>2709</u>	
				D. STREET ADDRESS (If rural, give location) <u>1431 Penridge Rd.</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	B. DATE OF BIRTH <u>3/24/98</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Clarence W. Spranthal</u>			14. MOTHER'S MAIDEN NAME <u>Anna Groener</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			6. SOCIAL SECURITY NO.		INFORMANT <u>Mr. William A. Henry</u> <u>Charles</u>
					ADDRESS <u>(Same)</u>
1B. <u>1750 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Metastatic Carcinoma of Ovary</u> DUE TO (B) _____ DUE TO (C) _____	
				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/14/66</u> 19 to <u>9/28/66</u> 19, that (I) (we) last saw the deceased alive on <u>9/28/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Leighton Siegel</u>				23B. DATE SIGNED <u>9/28/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Leighton Siegel</u>				23D. ADDRESS <u>M.D. Maryland General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/1/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 30 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>	



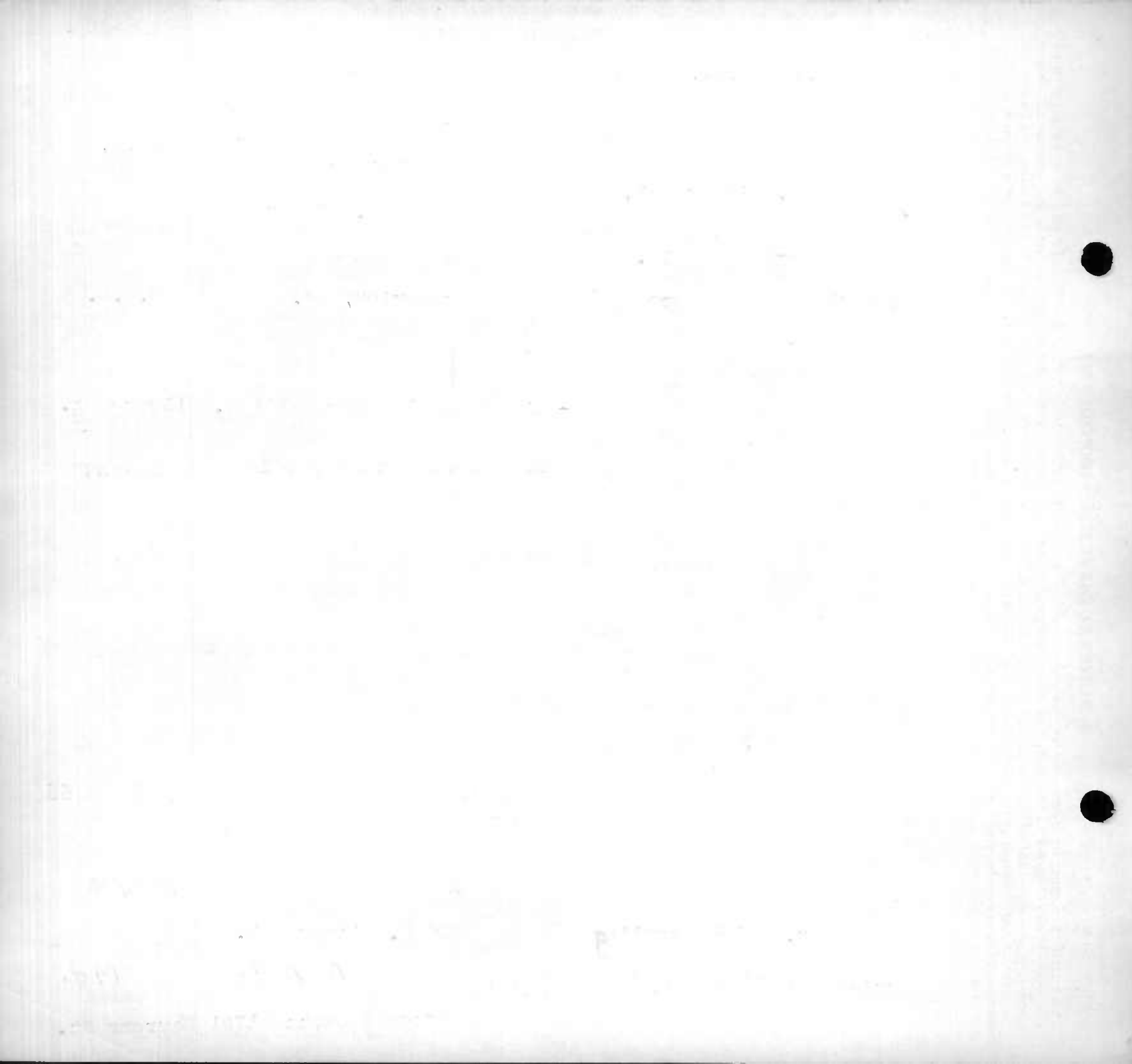


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09855				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09855	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Lucille Williams		9/28/66	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
00 906 N. Gilmore St.				Maryland			
5. SEX				6. RACE			
Fe				Negro			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH			
Wid.				April 27, 1867			
9. AGE (In years last birthday)				97			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
housewife				none			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Frederick, Md.				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unk				Unk			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
no				none-unk			
17. INFORMANT				ADDRESS			
Isabel Moody				906 N. Gilmore St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) Arteriosclerotic Cardio Vascular Disease			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
1 month							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 2/28/66 to 9/28/66, that (I) (we) last saw the deceased alive on 9/28/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Dr. Ralph Reckling				9/29/66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Ralph Reckling				426 N. Gilmore St.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				10-1-66			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
M.T. Oakbury				A. A. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
SEP 30 1966				Morton & Dyett			
25C. FUNERAL DIRECTOR				ADDRESS			
Morton & Dyett				1701 Laurens St.			





FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 09856		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09856	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>Bertha Lecato</b>			2. DATE AND HOUR OF DEATH <b>9-29-66 2:05 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Hospital</b> (If not in hospital or institution, give street address or location)			A. STATE <b>MARYLAND</b>		
			B. COUNTY <b>16-08</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
			D. STREET ADDRESS (If rural, give location) <b>3631 GELSTON DRIVE</b>		
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JUNE 3, 1918</b>	9. AGE (In years last birthday) <b>48</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>BALTO, MD</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>HOWARD HERSEY</b>			14. MOTHER'S MAIDEN NAME <b>ETHEL HILL</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>MRS. ETHEL HERSEY 1017 Aisquith Ave</b>		
18. <b>422.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Shock - Peritonitis</b> DUE TO (B) <b>Superior Mesenteric a. thrombosis</b> DUE TO (C) <b>ASCVD</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 hrs.</b>  <b>24 hrs.</b>  <b>years.</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>9/28/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>F-B</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/28/66</b> 19 <b>66</b> to <b>9/29</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/29</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>DWIGHT N. FORTIER</b>			M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/30/66</b>
23C. PHYSICIAN'S NAME (Type) <b>DWIGHT N. FORTIER</b>			23D. ADDRESS <b>M.D. 1518 BOLTON ST., BALTO. MD.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/4/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Ann Arundel Cty., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		25B. NAME OF REGISTRAR <b>Wm March</b>		25C. FUNERAL DIRECTOR ADDRESS <b>WM MARCH 928 E NORTH AVE,</b>	

1944-1945  
1946-1947

1948-1949

1950-1951

1952-1953

1954-1955

1956-1957

1958-1959

1960-1961

1962-1963

1964-1965

1966-1967

1968-1969

1970-1971

1972-1973

1974-1975

1976-1977

1978-1979

1980-1981

1982-1983

1984-1985

1986-1987

1988-1989

1990-1991

1992-1993

1994-1995

66 09857

BALTIMORE CITY HEALTH DEPARTMENT

66 09857

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT

JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

September 29, 1966

8:00 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

609 Greenwillow Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

3/15/12

9. AGE (In years last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Richmond Va

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

James Johnson

14. MOTHER'S MAIDEN NAME

Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-01-9068

17. INFORMANT

ADDRESS

Mrs Nellie Billups 702 Druid Hill Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/29/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/3/66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetry

23D. LOCATION

(City, town, or county)

Baltimore Md

(State)

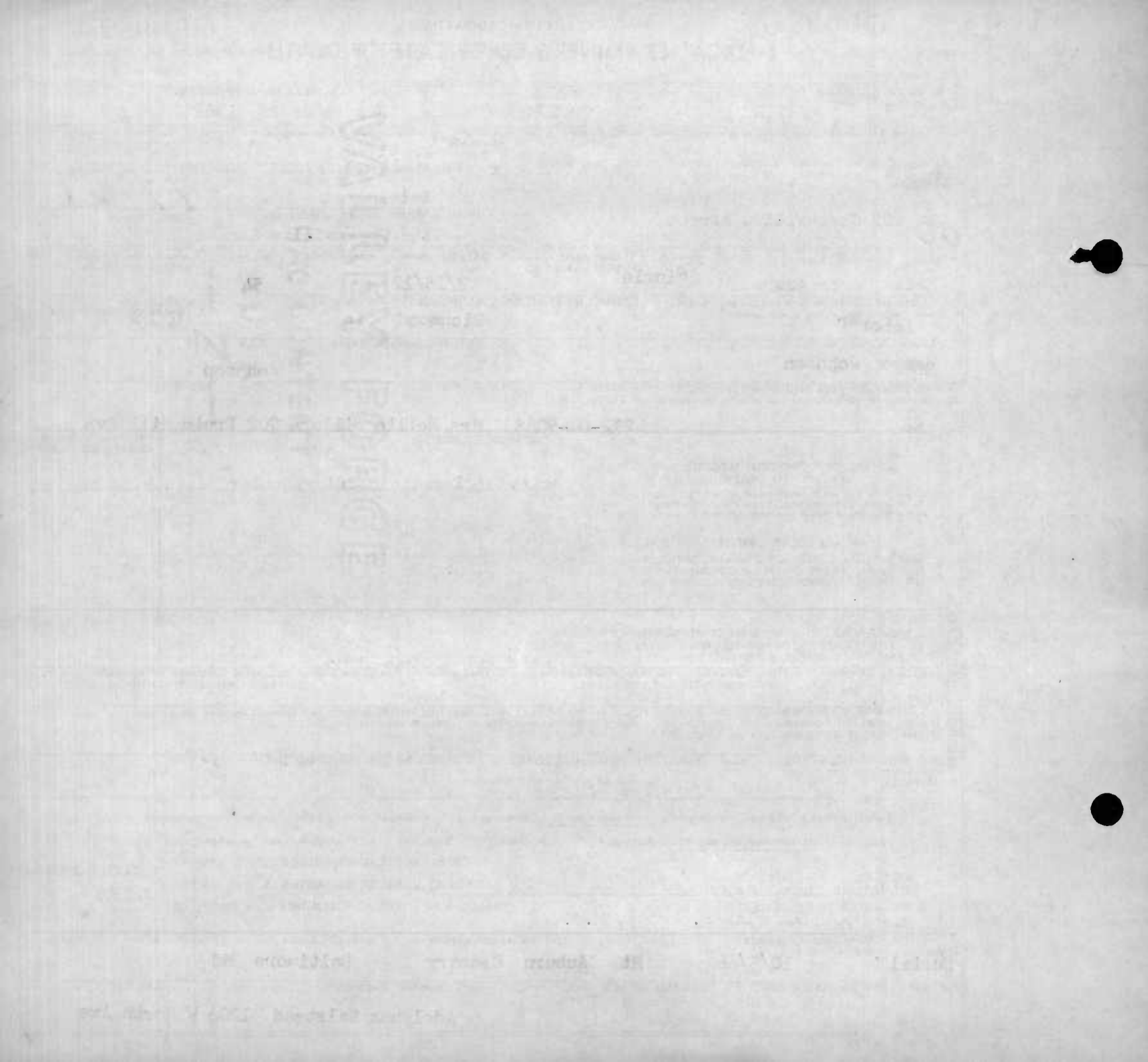
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Ave



1  
K. 530

66 09858

BALTIMORE CITY HEALTH DEPARTMENT

66 09858

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HENRY

KENNEDY

2. DATE AND HOUR PRONOUNCED DEAD

September 25, 1966

6:32 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

663 Vine Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

109 Arch Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

7-1-1912

9. AGE (In years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

PINEWOOD S.C

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

JAMES KENNEDY

14. MOTHER'S MAIDEN NAME

NORA KIND

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Kennedy 705 Mc Henry St.

18. 443 X 0021

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Hypertensive cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Pulmonary tuberculosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 26, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

9-29-66

23C. NAME of CEMETERY or CREMATORY

MOUNT AUBURN

23D. LOCATION

(City, town, or county)

BALTO Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 3 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

I. L. BROWN & SON 1234 MONTGOMERY ST.

WALL

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



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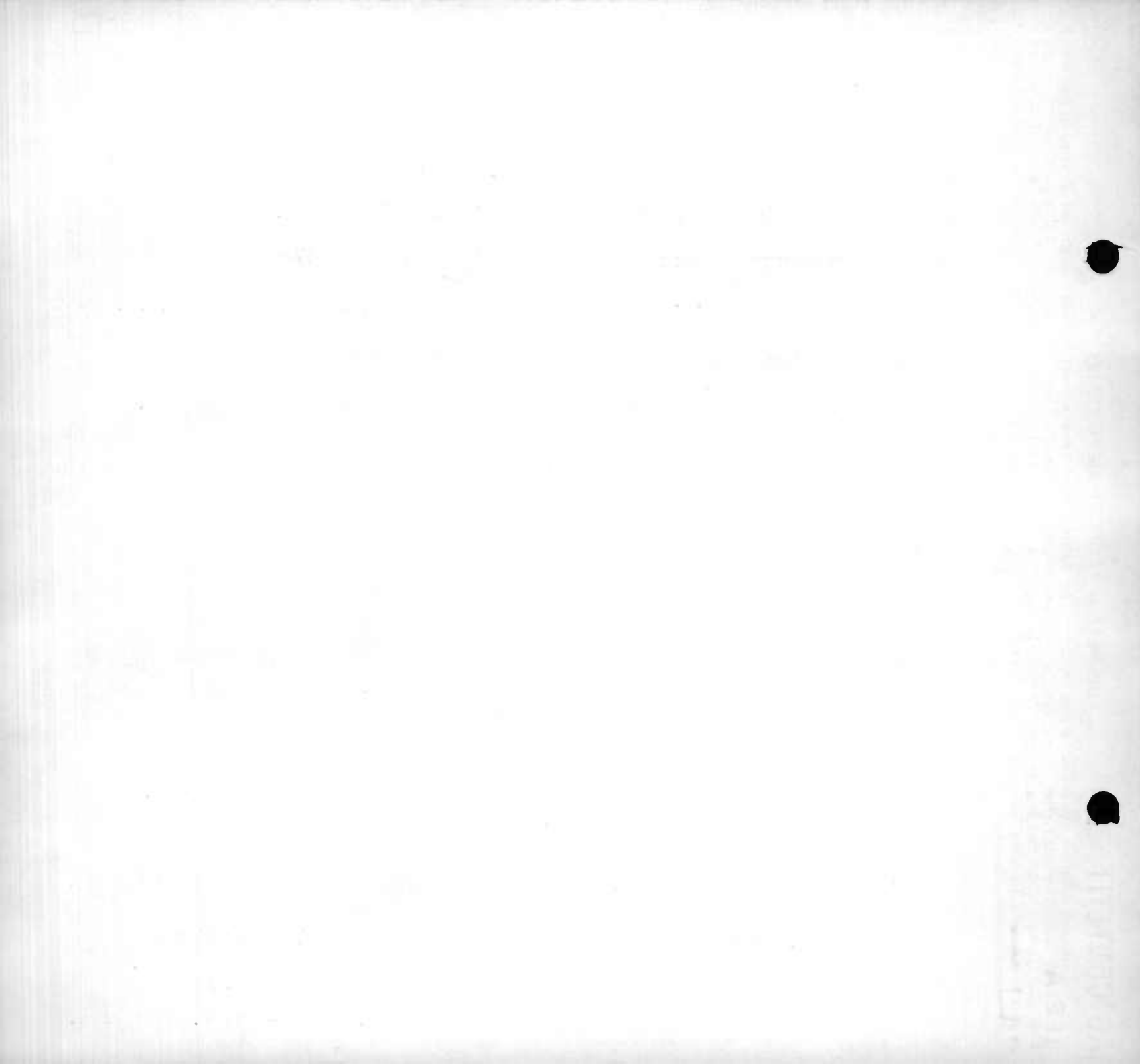
100-1-100

100-1-100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09860</b>	
BIRTH NO. <b>66 09860</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Humbert Dawkins</b>		2. DATE AND HOUR OF DEATH <b>9/30/66 7:10 AM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-06</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 The Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>2903 Clifton Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>12/25/18</b>	9. AGE (In years last birthday) <b>47</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Coast Guard-</b>		11. BIRTHPLACE (State or foreign country) <b>Princeton S.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Lewis Dawkins</b>		14. MOTHER'S MAIDEN NAME <b>Hester Beaks</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>251-10-0338</b>		17. INFORMANT ADDRESS <b>Viola Dawkins- 2903 Clifton Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>392X I</b>		CAUSE OF DEATH (A) <b>Acute renal failure &amp; Uremia</b> DUE TO (B) <b>Chronic Renal Disease</b> DUE TO (C) _____			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Probable MI</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (we) (this hospital) attended the deceased from <b>9/17 1966</b> to <b>9/30 1966</b> , that (we) last saw the deceased alive on <b>9/30 1966</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Murray A. Katz</b>				23B. DATE SIGNED <b>9/30/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Murray A. Katz</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/6/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>			
25B. NAME OF REGISTRAR <b>Herbert E. Nutter</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter-3035 W. North Ave.</b>			



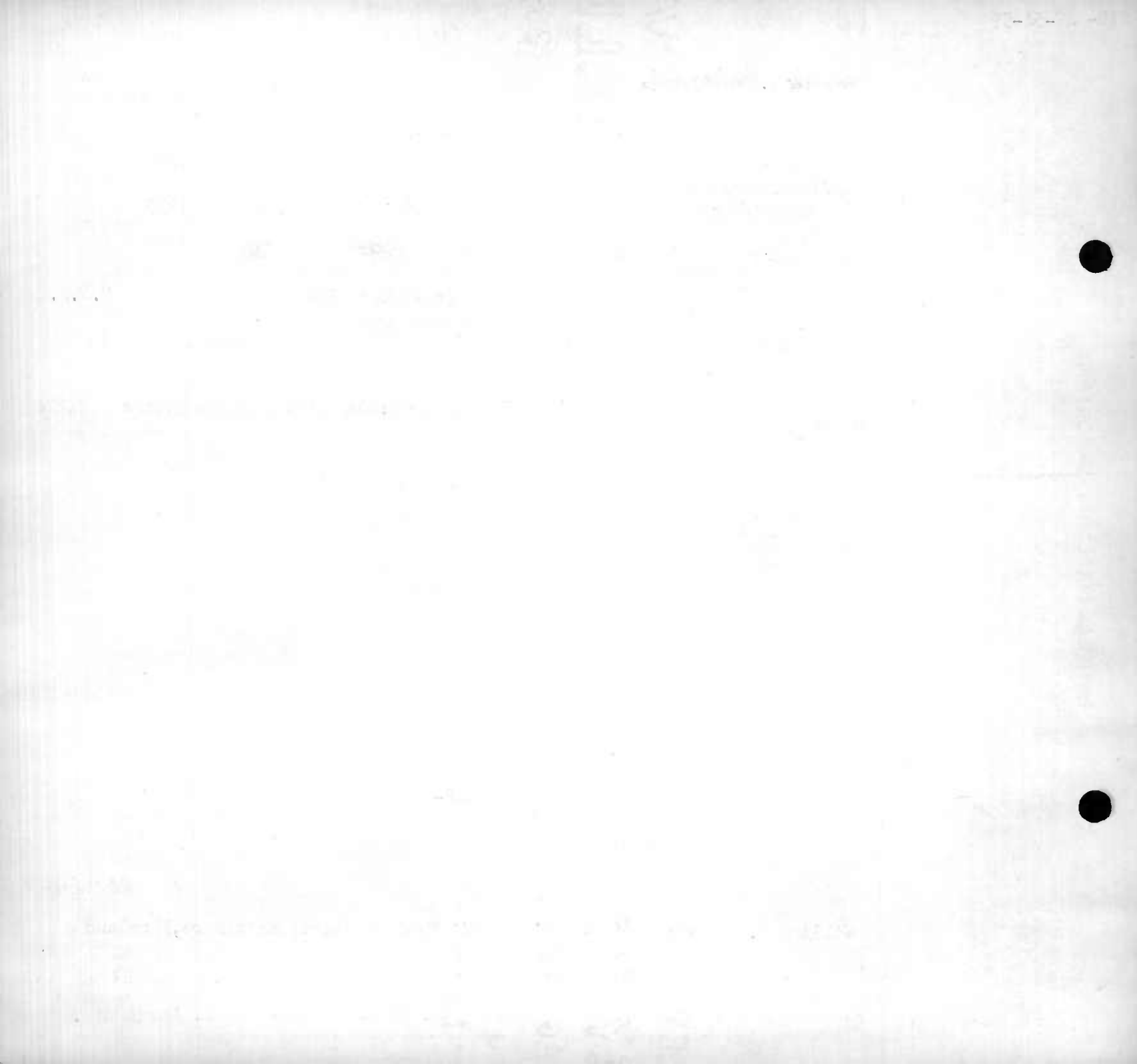
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

W. 634

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

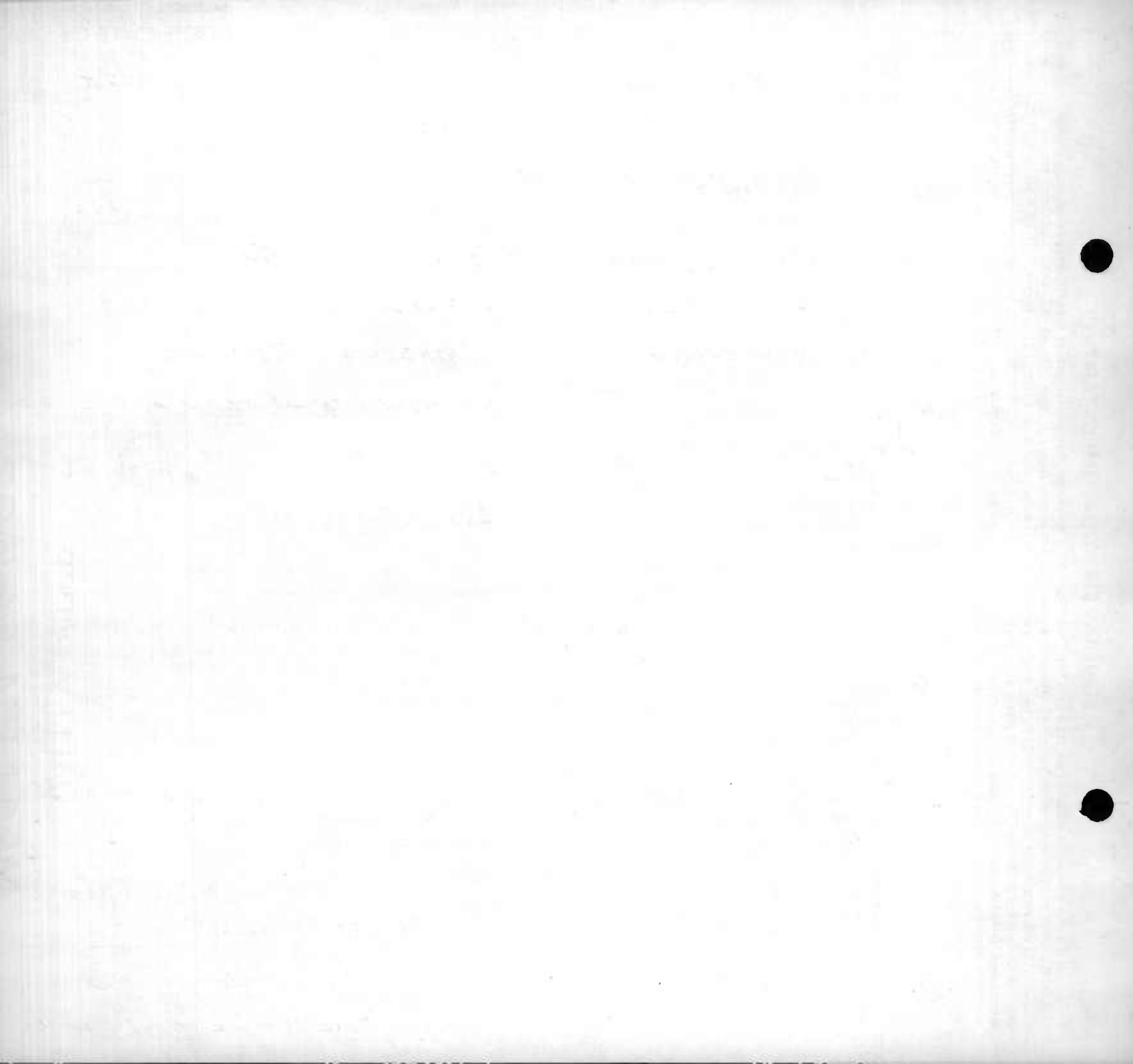
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Maggie C. Wardlaw</b>		2. DATE AND HOUR OF DEATH <b>9-30-66</b> <b>1755A</b> M.	
3. PLACE OF DEATH <b>Baltimore, MARYLAND</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-13</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
		D. STREET ADDRESS (If rural, give location) <b>2410 Oswego Avenue 21215</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED <b>Widowed</b>	8. DATE OF BIRTH <b>3-22-1896</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Glass Company</b>	9. AGE (In years lost birth) <b>70</b>
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Steven Childs</b>		14. MOTHER'S MAIDEN NAME <b>Harriet McLarin</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-10-7770-A</b>	
17. INFORMANT <b>Records: ECH</b>		ADDRESS <b>4940 Eastern Avenue 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Disseminated Carcinomatosis 8 mo.</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 mo.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>9-22-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>No</b>	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>(If in Baltimore City, give exact location)</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>No</b>	
21C. WHERE DID INJURY OCCUR? <b>(If in Baltimore City, give exact location)</b>		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-22-66</b> 19 to <b>9-30-66</b> 19, that <b>(I)</b> (we) last saw the deceased alive on <b>9-30-66</b> 19 and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Wm. A. Emerson</b>		23B. DATE SIGNED <b>9-30-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>William A. Emerson</b>		23D. ADDRESS <b>4940 Eastern Avenue, Baltimore, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/5/66</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		25B. NAME OF REGISTRAR <b>Herbert E. Nutter</b>	
25C. FUNERAL DIRECTOR <b>Herbert E. Nutter</b>		ADDRESS <b>3035 W. North Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09862</b>	
BIRTH NO. <b>66 09862</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <b>Ernest Wunderlich</b>		2. DATE AND HOUR OF DEATH <b>30 Sep 66</b> <b>745 A</b> M.	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Fayette Convalescent Home</b> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balt.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>27-05 Balt</b> D. STREET ADDRESS (If rural, give location) <b>4101 Chesley Ave 21206</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never Married SINGLE</b>	8. DATE OF BIRTH <b>23 Nov 1883</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUTCHER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MEAT</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>CONRAD WUNDERLICH</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE RIPPLE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS HENRIETTA LOSTADEN 2005 JEFFERSON</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CHF (acute)</b>		CAUSE OF DEATH (A) DUE TO <b>Branchitis (viral?)</b> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>past wk</b> <b>" 2 "</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>HCRD/rt. pericorneal scleral hemorrhage</b>		3d	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, public bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sep 19 61</b> to <b>30 Sep 19 66</b> , that (I) (we) last saw the deceased alive on <b>30 Sep 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J Hulla</b>				23B. DATE SIGNED <b>30 Sep 66</b>	
23C. PHYSICIAN'S NAME (Type) <b>J Hulla</b>				23D. ADDRESS M.D. <b>2214 E Fayette St 21231</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/3/66</b>		24C. NAME of CEMETERY or CREMATORY <b>ST. MATTHEWS</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>			
25B. NAME OF REGISTRAR <b>P. E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>ULLICH FUNERAL HOME 4210 BELAIR</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		Baltimore City Health Department		Registered No. 66 09863	
1. NAME OF DECEASED (Type or Print) William C. Zinn			2. DATE AND HOUR OF DEATH September 28, 1966 2:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Convales-arium 90			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. CITY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-01 D. STREET ADDRESS (If rural, give location) 4601 Benton Heights Ave.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Oct. 26, 1903	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Steel	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William C. Zinn			14. MOTHER'S MAIDEN NAME Margaret		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Marlene Stinemire 4601 Benton Heights		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO Carcinomatosis (B) DUE TO Bronchogenic Carcinoma, R. Lung (C)		INTERVAL BETWEEN ONSET AND DEATH ? ?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/15/66 19 to 9/28 1966, that (I) (we) last saw the deceased alive on 9/27/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley			23B. DATE SIGNED 9/30/66		
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley			23D. ADDRESS 4900 Belair Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/30/66		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Parkville, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 3 1966		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.	



2-20-9

Carrollton  
Bridge, Va., etc.

etc.

8/2/10

Mr. O. C. ...

W. 562

66 09864

BALTIMORE CITY HEALTH DEPARTMENT

66 09864

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES F. WAINWRIGHT

2. DATE AND HOUR PRONOUNCED DEAD

September 29, 1966 1:25 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3133 #1mora Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3133 Elmora Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 1, 1900

9. AGE (In years last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machine operator

10B. KIND OF BUSINESS OR INDUSTRY

Shoe Mfrgr.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel E. Wainwright

14. MOTHER'S MAIDEN NAME

Mamie Abell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Anna Wainwright 3133 Elmora Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/29/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

10/3/66

23C. NAME of CEMETERY or CREMATORY

Lorraine Cemetery

23D. LOCATION

(City, town, or county)

(State)

Woodlawn, Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 3 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

ADDRESS

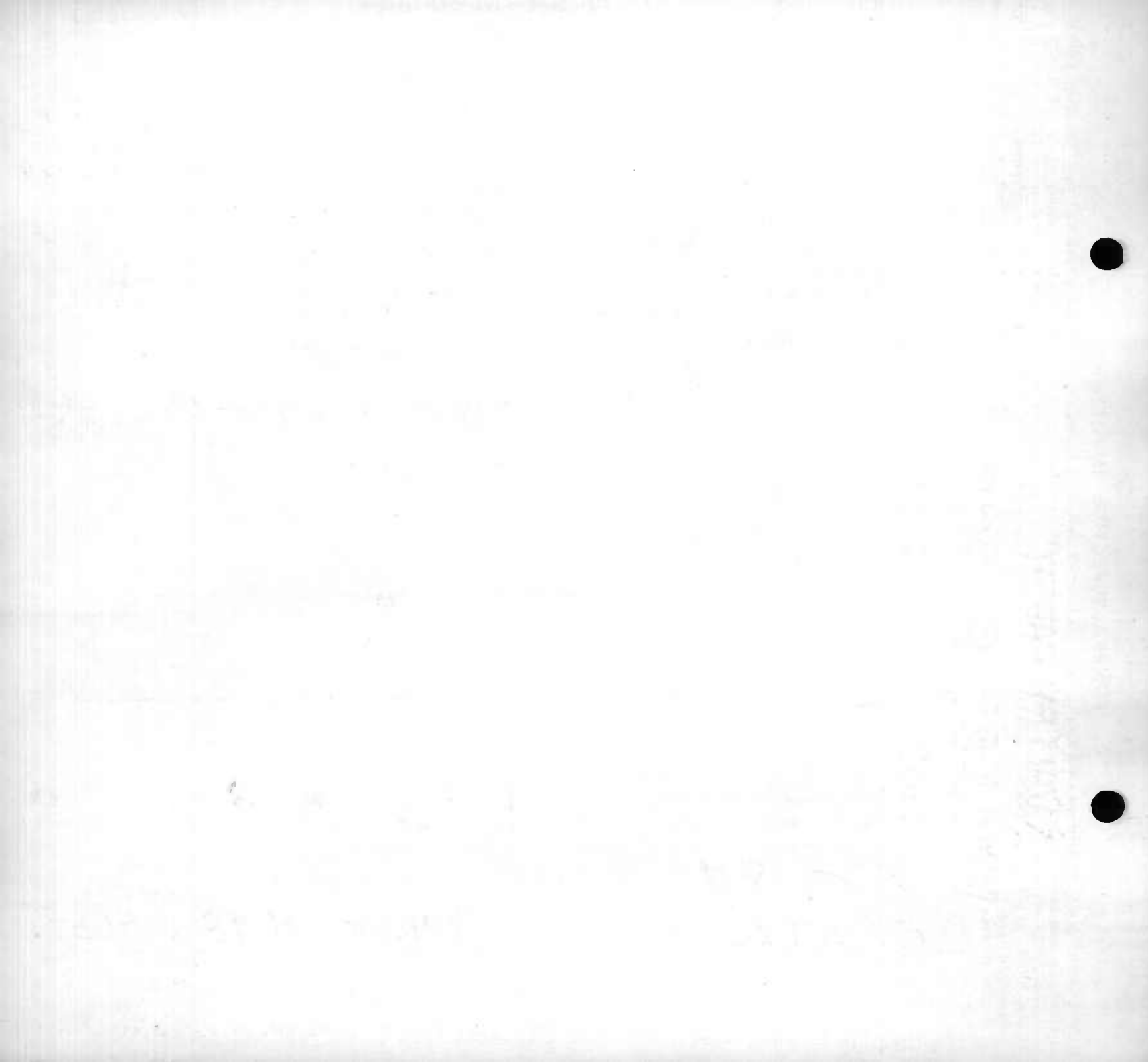
Ullrich Funeral Home 4210 Belair Road

W/101114  
F000000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

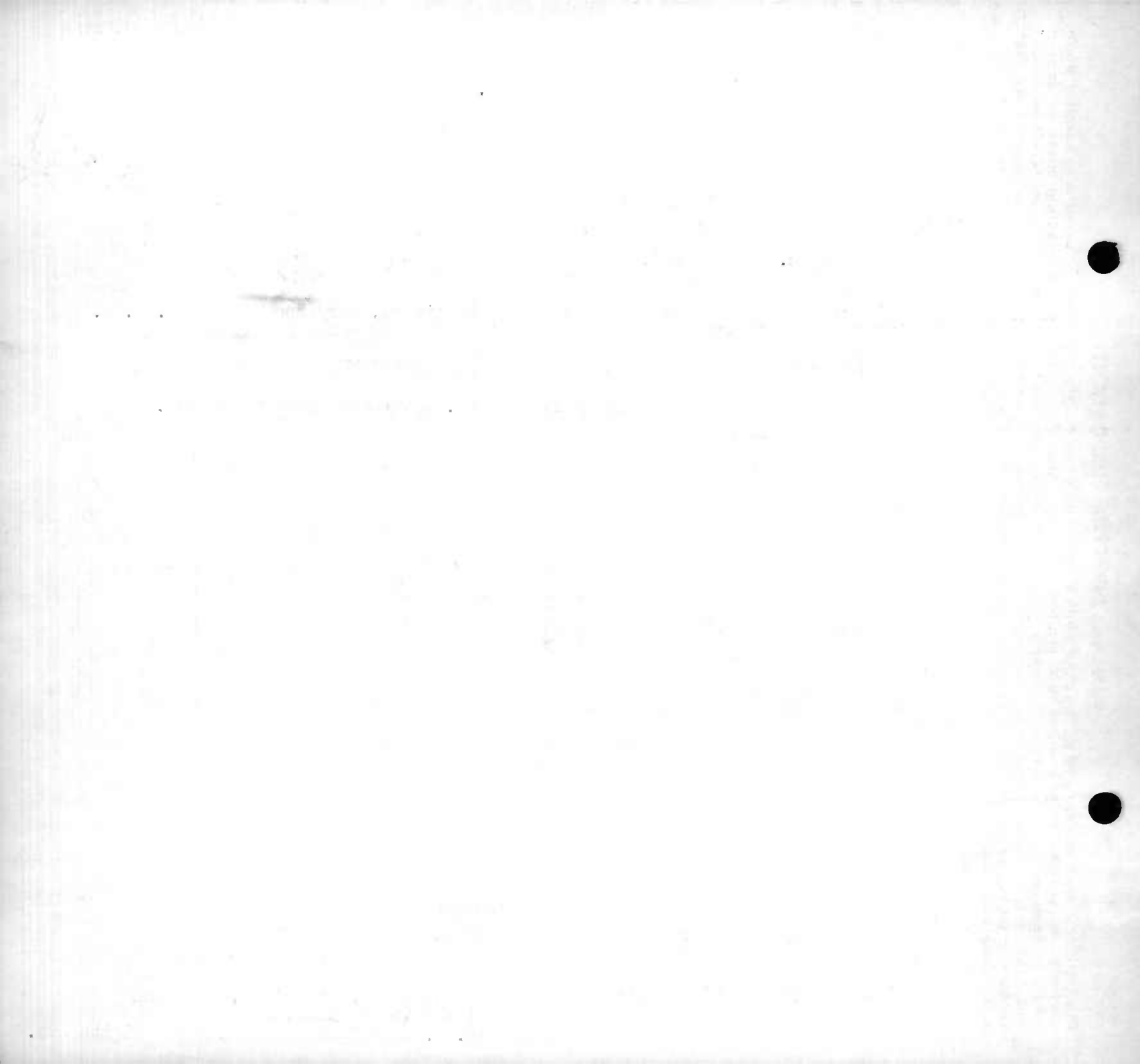
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
M.E. CASE NO.				CERTIFICATE OF DEATH				66 09865			
1. NAME OF DECEASED (Type or Print) <i>McGinty, Mr. John T.</i>				2. DATE AND HOUR OF DEATH <i>10/1/66 . 4 o'clock a.m.</i>				M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				A. STATE			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Home - Hospital</i>				B. COUNTY <i>Baltimore</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>DUNDALK 53-00</i>			
(If not in hospital or institution, give street address or location) <i>35</i>				D. STREET ADDRESS (If rural, give location) <i>1784 BROOKVIEW RD</i>							
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widower</i>		8. DATE OF BIRTH <i>4/25/07</i>		9. AGE (In years last birthday) <i>59</i>		If Under 1 Yr. Months Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SPRINKLER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>STEEL</i>		11. BIRTHPLACE (State or foreign country) <i>Pa. MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>					
13. FATHER'S NAME <i>Peter J. McGinty</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Fitzmorris</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>213-07-7826</i>		17. INFORMANT <i>JOHN M. MCGINTY JR - 1960 CHURCH RD</i>				ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of Stomach</i>				CAUSE OF DEATH (A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO							
(C) DUE TO											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>9/20/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma metastasis</i>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <i>9-6-66</i> to <i>10-1-66</i> , that (I) (we) last saw the deceased alive on <i>10-1-66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>C. Stella</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>10/1/66</i>					
23C. PHYSICIAN'S NAME (Type) <i>C. STELLA</i>				M.D. ADDRESS <i>CHURCH HOME - HOSP.</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10/4/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>OAK LAWN CEMETERY</i>		24D. LOCATION (City, town, or county) (State) <i>COLGATE MD</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 3 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>ULLRICH FUNERAL HOME</i>		ADDRESS <i>DUNDALK MD</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09866</b>	
BIRTH NO. <b>66 09866</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>SAPP, HARRY</b>		2. DATE AND HOUR OF DEATH <b>9/28/66</b> <b>1:35 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-17</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSP. OF BALTO.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b>			
		D. STREET ADDRESS (If rural, give location) <b>5306 MAPLE AVE</b>			
5. SEX <b>Male</b>	6. RACE <b>Cauc.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>7-27-87</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 1</b>		16. SOCIAL SECURITY NO. <b>215 03 1718</b>		17. INFORMANT ADDRESS <b>Mrs. Ruth Sapp 5306 Maple Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>260X I</b>		CAUSE OF DEATH (A) DUE TO <b>Severe diabetic acidosis</b> (B) DUE TO <b>Diabetic mellitus</b> (C) DUE TO <b>Pulmonary insufficiency, severe</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 day</b> <b>many years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>6</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>(X) No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 28, 1966</b> to <b>Sept 28, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 28, 1966</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Gerardo Ypil Jr. M.D.</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/28/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>GERARDO YPIL JR. M.D.</b>		23D. ADDRESS <b>SINAI HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>30 SEP 66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION <b>Catonsville, Maryland</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		25B. NAME OF REGISTRAR <b>J. E. Lowell</b>		25C. ADDRESS <b>4611 Park Heights Ave.</b>	

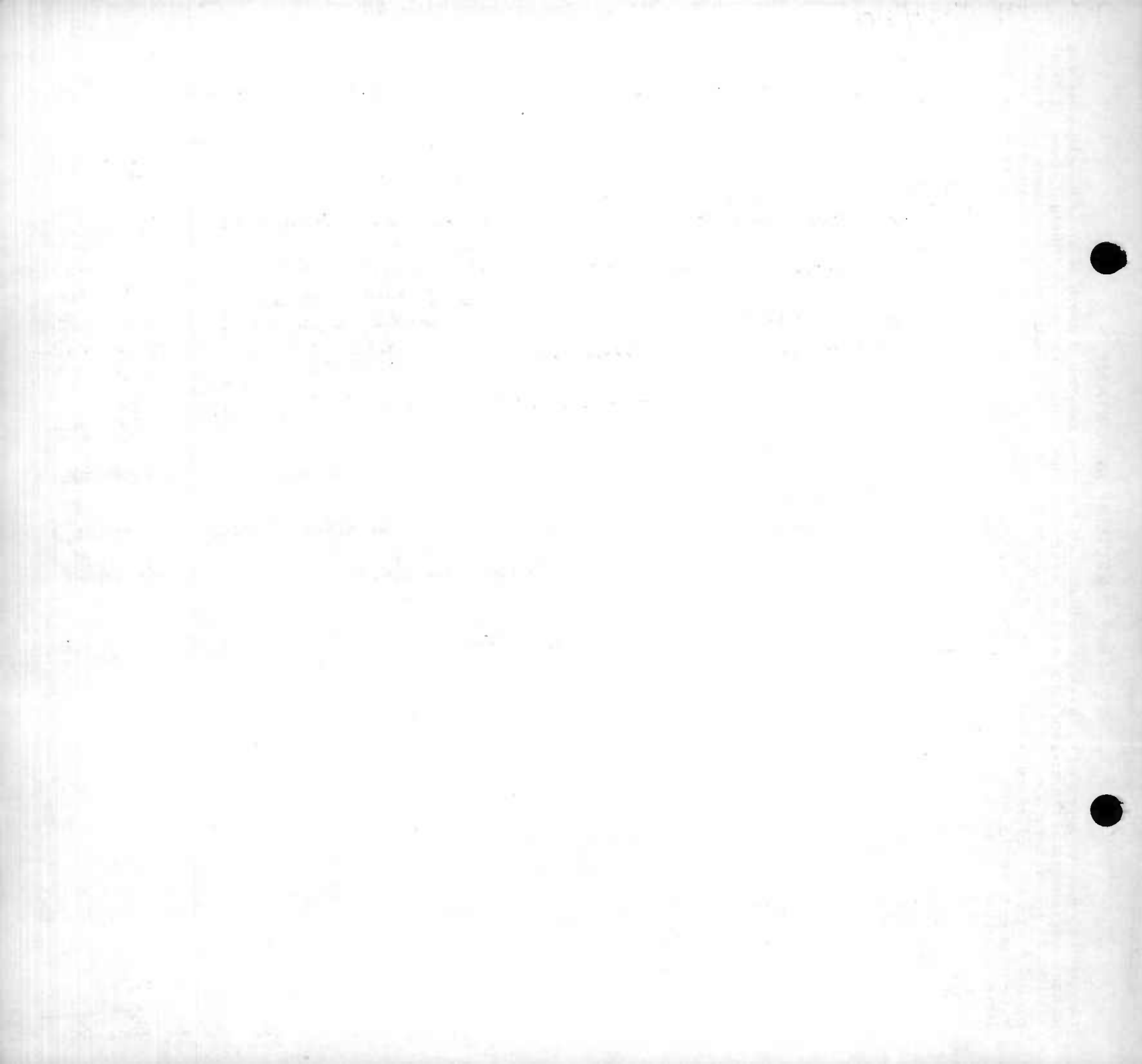


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M1460 BIRTH NO. 66 09867		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 09867	
1. NAME OF DECEASED (Type or Print) <i>Miller, Sophie</i>			2. DATE AND HOUR OF DEATH <i>Sept. 29, 1966, 10:00 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>42 Sinai Hospital of Baltimore</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Baltimore, Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>27-20 6512 Park Heights Ave.</i>		
5. SEX <i>Fe.</i>	6. RACE <i>Cauc.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>3/14/1900</i>	9. AGE (in years last birthday) <i>66</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Abraham Sharfman</i>			14. MOTHER'S MAIDEN NAME <i>Ida Cohen Sharfman</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>218-258-868</i>	17. INFORMANT <i>Gennie B. Miller</i>		ADDRESS <i>Same as dec.</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <i>420.04-260X</i>			CAUSE OF DEATH (A) <i>Congestive heart failure</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <i>Arteriosclerotic heart disease</i> DUE TO		<i>years</i>
			(C) <i>Renal failure</i>		<i>months</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes mellitus</i>			<i>19 years</i>		
19A. DATE OF OPERATION <i>—</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>—</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>—</i>	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>Sept. 14, 1966</i> to <i>Sept. 29, 1966</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>Sept. 29, 1966</i> and that in <i>(my)</i> <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> <i>(did)</i> <i>(did not)</i> view the body after death.					
23A. SIGNATURE <i>Erwin H. Hesselberg</i>				23B. DATE SIGNED <i>Sept. 29, 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>Erwin H. Hesselberg</i>		23D. ADDRESS <i>Sinai Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Oct 2 1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Linshire in Rosedale Md.</i>	
24D. LOCATION (City, town, or county) (State) <i>—</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 3 1966</i>			
25B. NAME OF REGISTRAR <i>—</i>		25C. FUNERAL DIRECTOR <i>Jack Harris</i>			
25D. ADDRESS <i>2100 Canton Rd</i>					

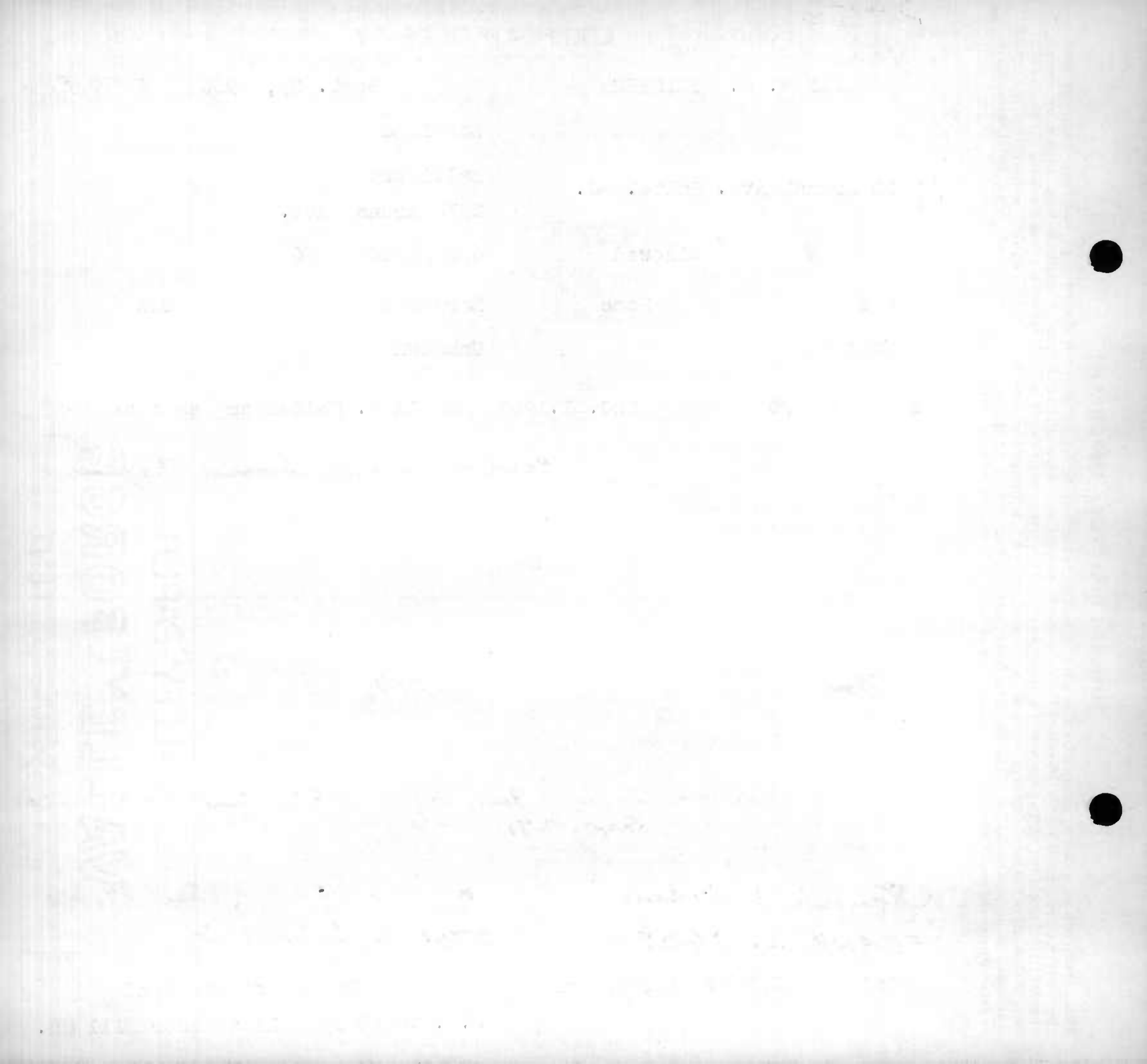




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 09868</u>	
BIRTH NO. <u>66 09868</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>HELEN R. J. BILLMYER</b>		2. DATE AND HOUR OF DEATH <b>Sept. 29, 1966 5:50 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <u>Kerson</u> (If not in hospital or institution, give street address or location) <b>2922 Arunah Ave. Balto. Md.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2938 Arunah Ave.</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED <b>Widowed</b>	8. DATE OF BIRTH <b>6/28/1880</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years lost birthday) <b>86</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220.01.1202</b>	
17. INFORMANT <b>Donald F. Heiderman</b>		ADDRESS <b>same as # 4</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardio-Vascular Disease</b> (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO (C) DUE TO <b>3 years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>✓</b>			
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 10, 1963</u> to <u>Sept. 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept. 29, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Frank N. Ogden</b>		23B. DATE SIGNED <b>Sept. 29, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>FRANK N. OGDEN</b>		23D. ADDRESS <b>2701 N. Calvert St</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/3/66</b>	
24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fortune</b>	
25C. FUNERAL DIRECTOR <b>J.T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd.</b>	



## CERTIFICATE OF DEATH

Registered No. 66 09869

BIRTH NO. 66 09869

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Marie Franklin

2. DATE AND HOUR OF DEATH

9/27/66

5:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

4940 EASTERN AVENUE

BALTIMORE, MD. #21213

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore

8-05

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

1821 N. Caroline St. #21213

5. SEX

female negro

6. RACE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

unwed

8. DATE OF BIRTH

12/29/08

9. AGE (In years)

57

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

unknown

10B. KIND OF BUSINESS OR INDUSTRY

unknown

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Elijah Bedford

14. MOTHER'S MAIDEN NAME

Suzie Jones

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

012-05-5326

17. INFORMANT

ADDRESS

1) RECORDS: BCH 4940 EASTERN AVE. BALTO., MD.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Carcinoma of the cervix

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

6 mos.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At  
Work ☐Not White  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/14 1966 to 9/27 1966.  
that (I) (we) last saw the deceased alive on 9/27 1966 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Bruce M. Dow

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

9/27/66.

23C. PHYSICIAN'S  
NAME (Type)

BRUCE M. DOW

M.D.

23D. ADDRESS 4940 EASTERN AVENUE  
BALTO. City Hosps.

BALTIMORE, MD. #21213

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/3/66

24C. NAME OF CEMETERY or CREMATORY

Balto. National

24D. LOCATION

5501 Frederick Ave

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 3 1966

25B. NAME OF REGISTRAR

Robert E. Jackson

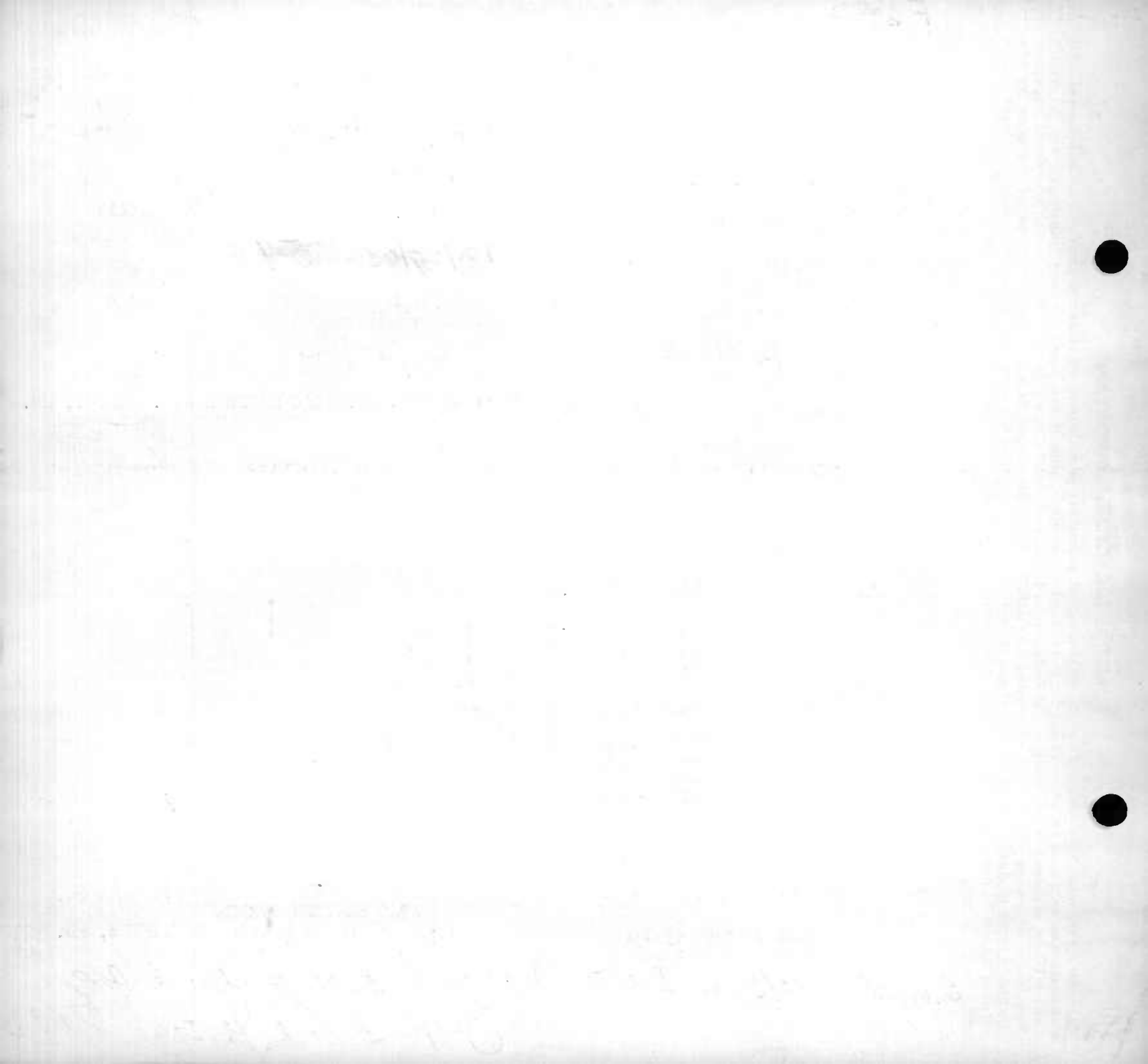
25C. FUNERAL DIRECTOR

Joseph B. Locks 1304 N. Central Ave

ADDRESS

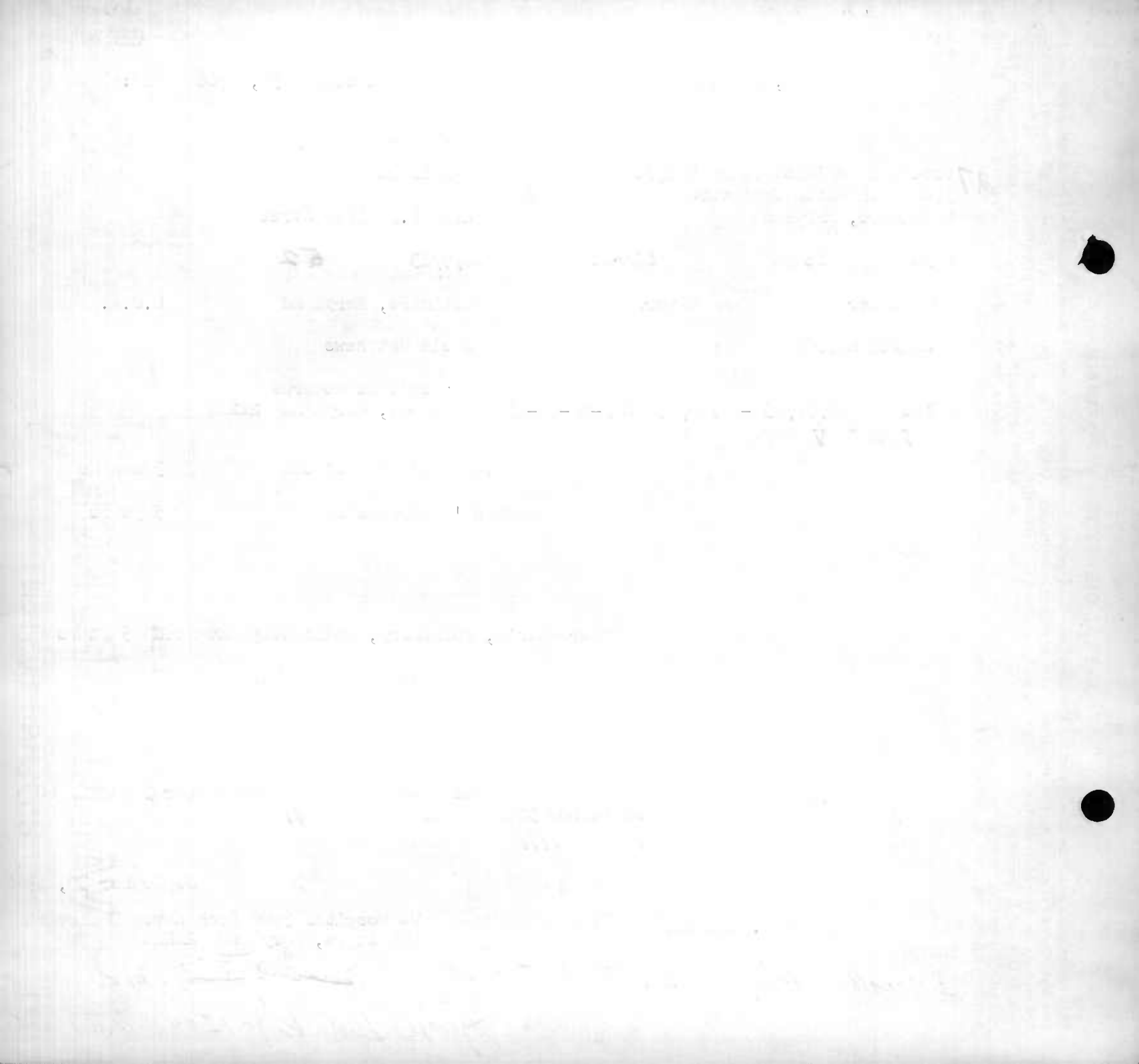
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09870</u>	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <u>66 09870</u></p> <p>M.E. CASE NO. <u>66 09870</u></p> </div> <div style="text-align: center;"> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> </div> </div>					
<p>1. NAME OF DECEASED (Type or Print) <u>MURRAY, Samuel NMI</u></p>			<p>2. DATE AND HOUR OF DEATH <u>September 30, 1966</u> <u>10:40</u> <u>A</u> M.</p>		
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland</u></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>8-03</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2718 E. Oliver Street</u></p>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>10/9/13</u>	9. AGE (In years last birthday) <u>52</u>	<p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Samuel Murray</u>			14. MOTHER'S MAIDEN NAME <u>Susie Matthews</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>10/30/43 - 1/15/45</u>		16. SOCIAL SECURITY NO. <u>213-20-74-83</u>	17. INFORMANT ADDRESS <u>VA Hospitals Records</u> <u>Baltimore, Maryland 21218</u>		
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>15504-002.1</u> <u>Hepatitis with metastases</u></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Laennec's cirrhosis</u></p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Tuberculosis, pulmonary, moderately advanced 5 years</u></p>			<p>CAUSE OF DEATH</p> <p>(A) DUE TO <u>Hepatitis with metastases</u> <u>3 months</u></p> <p>(B) DUE TO <u>Laennec's cirrhosis</u> <u>5 years</u></p> <p>(C) _____</p>		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>yes</u>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
<p>22. I certify that <u>11</u> (this hospital) attended the deceased from <u>August 1st</u> <u>1966</u> to <u>September 30th</u> <u>1966</u>, that <u>1</u> (we) last saw the deceased alive on <u>September 30th</u> <u>1966</u> and that in <u>11</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>11</u> (We) (did) (did not) view the body after death.</p>					
23A. SIGNATURE  <u>Ralph H. Twining</u>				23B. DATE SIGNED <u>September 30, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>RALPH H. TWINING</u>				23D. ADDRESS <u>VA Hospital 3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/4/66</u>	24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 3 1966</u>		25B. NAME OF REGISTRAR <u>Paul E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Joseph L. Locks</u> <u>13047 Central Ave</u>	

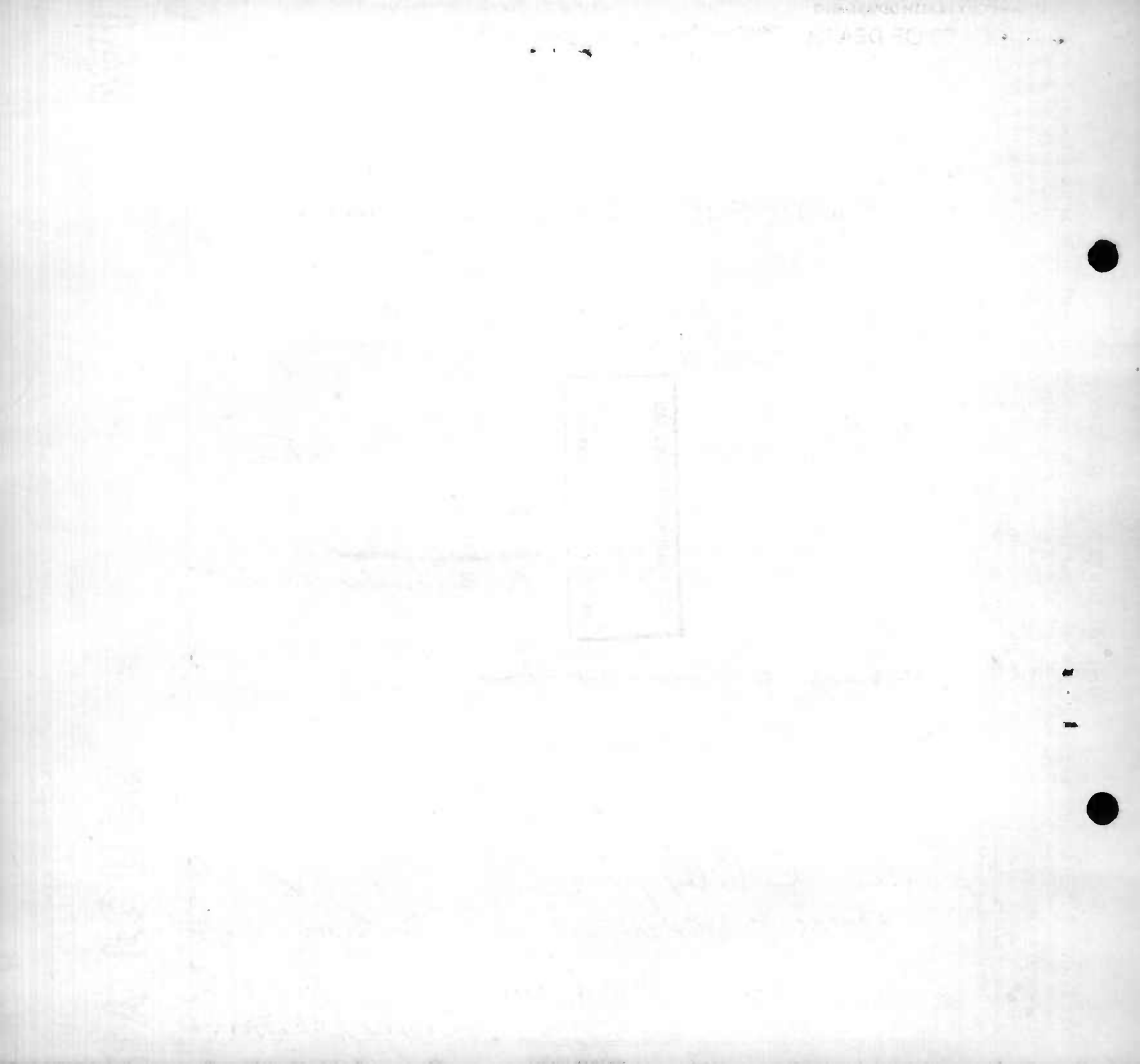


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09871		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09871	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SUMTER BALDWIN		2. DATE AND HOUR OF DEATH 9-29-66 10 <sup>30</sup> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 16-04 C. CITY OR TOWN Baltimore D. STREET ADDRESS (If rural, give location) 1810 Mosher ST.			
5. SEX male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 8-24-01	9. AGE (In years last birthday) 64 yrs	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Va	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME David Baldwin			14. MOTHER'S MAIDEN NAME —		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. M.D.		17. INFORMANT Chaet	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, rise to the above cause (A) stating UNDERLYING CONDITION last.		<div style="border: 2px solid black; padding: 5px; display: inline-block;"> NOT A MEDICAL EXAMINER'S CASE M.D. CHIEF OR ASST. MEDICAL EXAMINER M.D. </div>		CAUSE OF DEATH Carcinoma of Rectum Congestive heart failure Fracture femur Cardiovascular accident	
INTERVAL BETWEEN ONSET AND DEATH					
19. DATE OF OPERATION 9-8-66 19. CONDITION FOR WHICH OPERATION WAS PERFORMED Paralytic, Cerebral, Fracture					
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-19-66 to 9-29-66, that (I) (we) last saw the deceased alive on 9-29-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lucas C. Vidhyaphum M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) LUCAS C. VIDHYAPHUM M.D.				23D. ADDRESS Lutheran Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/3/66		24C. NAME OF CEMETERY or CREMATORY Churchman	
24D. LOCATION Crystal Hill Md		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 3 1966		25B. NAME OF REGISTRAR R. E. Johnson		25C. FUNERAL DIRECTOR George S. Nelson	





R. 200

66 09872

BALTIMORE CITY HEALTH DEPARTMENT

66 09872

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>MARY ROWE</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>September 29, 1966 1:05 P</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>39 Provident Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1616 Gwynns Falls Parkway</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>9-15-95</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>68</b>
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Howard</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Howard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-30-9210</b>	17. INFORMANT ADDRESS <b>Annie Ferrell 525 Cherry Hill Rd.</b>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive and Arteriosclerotic Cardiovascular Disease.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		DATE SIGNED <b>9/30/66</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23B. DATE <b>10-3-66</b>	23C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	23D. LOCATION (City, town, or county) (State) <b>Arbutus Maryland</b>
24A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Feltner</b>	24C. FUNERAL DIRECTOR ADDRESS <b>George Kelson 1348 N. Calhoun St.</b>

WALTON & CO. LTD.

WALTON & CO. LTD.

WALTON & CO. LTD.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09873</b>	
BIRTH NO. <b>66 09873</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>William H. Herring</b>		2. DATE AND HOUR OF DEATH <b>9-27-66</b> <span style="float: right;">M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <b>3412 Auchentoroly Terrace</b>		A. STATE <b>Md.</b> B. COUNTY <b>1304</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto.</b>			
		D. STREET ADDRESS (If rural, give location) <b>3412 Auchentoroly Terrace</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>3-26-88</b>	9. AGE (In years last birthday) <b>78yrs.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Texas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Herring</b>		14. MOTHER'S MAIDEN NAME <b>Sarah</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>006-34-5696</b>		17. INFORMANT ADDRESS <b>Viola Herring 3412 Auchentoroly Ter.</b>	
18. <b>450.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerosis</b>		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>8yrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>6-1-1961</b> to <b>9-27-1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>9-26-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Percival C. Smith</b> M.D.				23B. DATE SIGNED <b>9-30-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Percival C. Smith</b> M.D.				23D. ADDRESS <b>1709 Gwynns Falls Parkway</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-3-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Carver Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Laurel, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George Kelson 1348 N. Calhoun Street</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 09874		CERTIFICATE OF DEATH		Registered No. 66 09874		
1. NAME OF DECEASED (Type or Print) ROSE MARY CHERIGO				2. DATE AND HOUR OF DEATH Sept. 29, 1966 10:20 a. M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 141 N. Linwood Ave., Baltimore, Md., 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md., 21212 B. COUNTY 27-38 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1114 Sherwood Ave.						
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 5/30/1893		9. AGE (In years last birthday) 72	10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Mach. Opr.			10B. KIND OF BUSINESS OR INDUSTRY Standard Overall		11. BIRTHPLACE (State or foreign country) New Haven, Conn.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Michael Sepio				14. MOTHER'S MAIDEN NAME Rose Bonner						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 214-01-2642A		17. INFORMANT John L. Cherigo, husband, above				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Myocardial infarct - Post operation - for operation approx. 6 weeks ago. (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (the hospital) attended the deceased from 19 to 9/29 1966, that (I) (we) last saw the deceased alive on 9/29 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE Joseph R. Liberto				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/30/66				
23C. PHYSICIAN'S NAME (Type) Dr. Joseph R. Liberto				23D. ADDRESS 3508 Bank Street						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/3/66		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. OCT 3 1966		25B. NAME OF REGISTRAR R. E. Feltner		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		ADDRESS				

My dear friend  
I am so glad to hear  
from you and hope you  
are well.

Yours truly  
John R. Allen

1/2/90

1/2/90

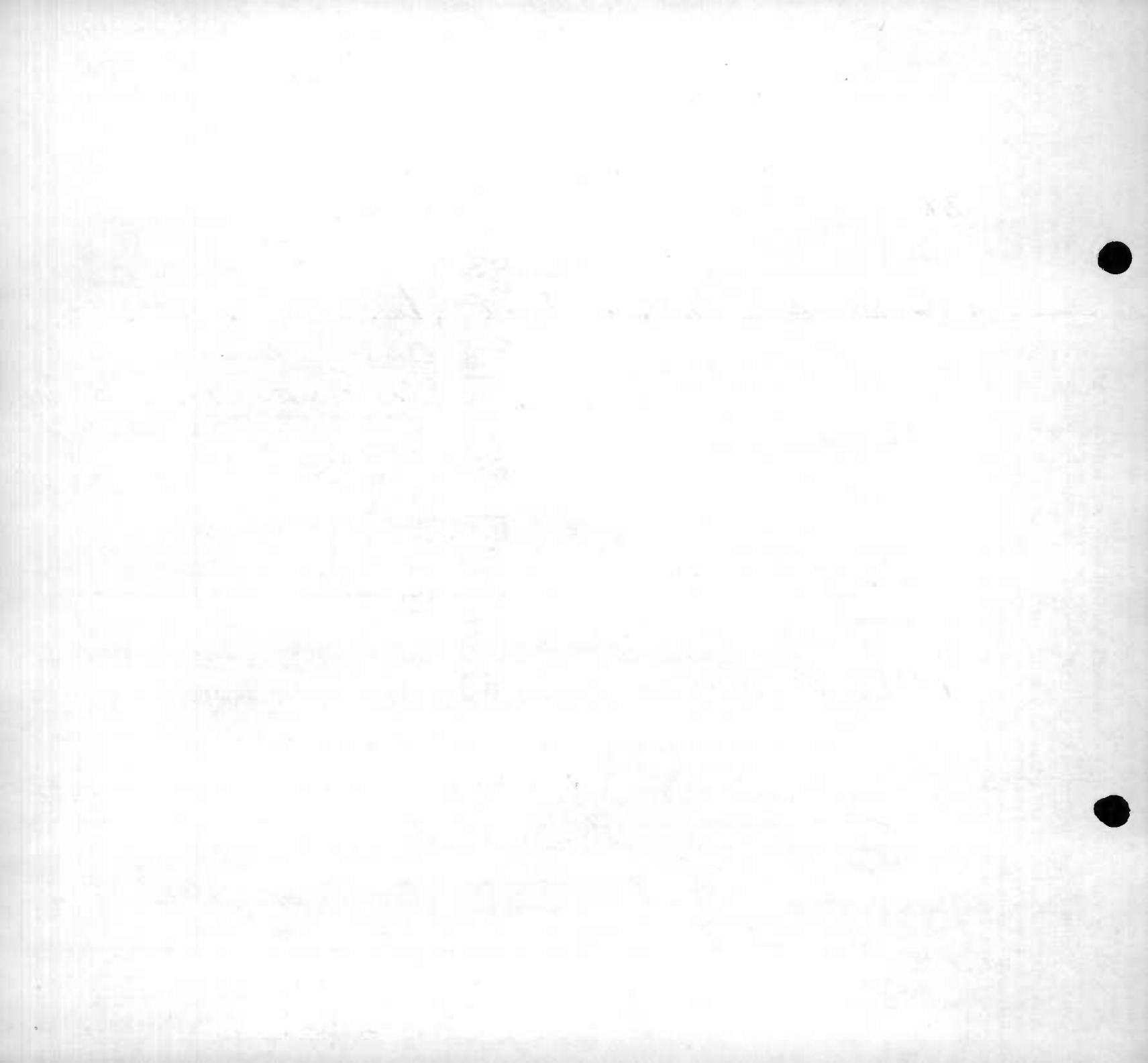


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. <b>66 09875</b>					
BIRTH NO. <b>66 09875</b>					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>LEVI FORRESTER</b>					2. DATE AND HOUR OF DEATH <b>1045 AM 22 Sept 66</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY HOSPITAL</b>					A. STATE <b>MD</b> B. COUNTY <b>Carroll Co</b>					
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Manchester 56-00</b>					
					D. STREET ADDRESS (If rural, give location) <b>R.D. #1</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>12/12/14</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Driver</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Transit</b>			11. BIRTHPLACE (State or foreign country) <b>MD</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Levi Forrester</b>					14. MOTHER'S MAIDEN NAME <b>Irene Dawson</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>217-03-9844</b>		17. INFORMANT <b>Mrs. Euna Forrester, Manchester, Md.</b>				ADDRESS	
18. <b>163X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Basal Tumor Metastatic</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinoma of Lung</b>					CAUSE OF DEATH <b>Basal Tumor Metastatic</b> <b>Carcinoma of Lung</b>					INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <b>22 Sept 66</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Angiogram</b>			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>9/19</b> 19 <b>66</b> to <b>9/22</b> 19 <b>66</b> , that (I) <b>was</b> last saw the deceased alive on <b>9/22</b> 19 <b>66</b> and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>was</b> (did) (did not) view the body after death.										
23A. SIGNATURE <b>Michael B. Flynn</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>22 Sept 66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Michael B. Flynn</b>					23D. ADDRESS <b>Univ. Hosp</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>OCT 3 1966</b>			24C. NAME OF CEMETERY or CREMATORY <b>Manchester Baptist</b>			24D. LOCATION <b>Manchester Carroll Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR <b>Tipton-Eline</b>			ADDRESS <b>Hampstead, Md.</b>	

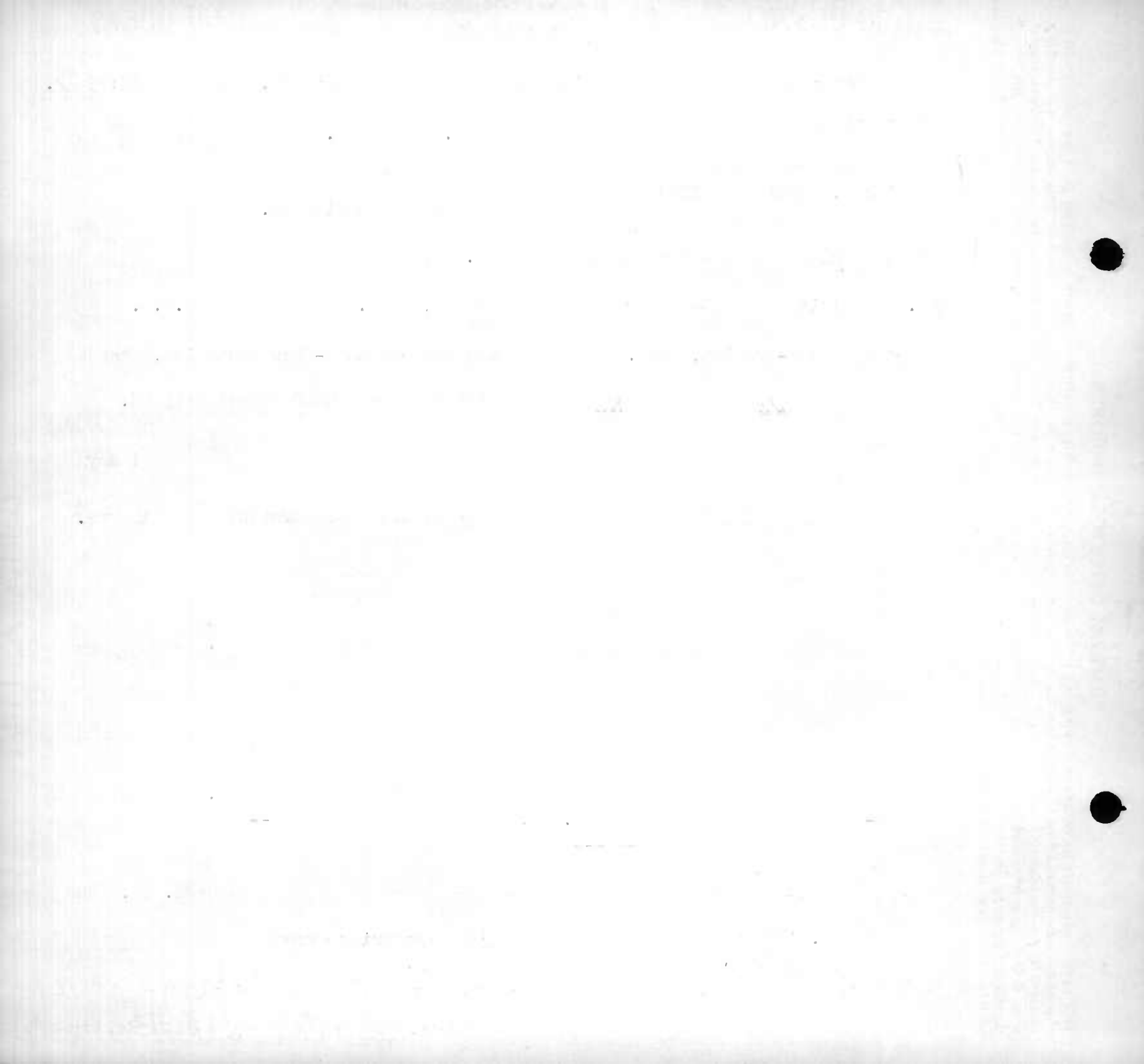




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09876</b>	
BIRTH NO. <b>66 09876</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Sister de Sales Yendley (Elizabeth)</b>		<b>September 28, 1966</b>   <b>12:25 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
<b>Villa Saint Michael</b> <small>FULL NAME OF (If not in hospital or institution, give street)</small> <small>HOSPITAL OR address or location)</small> <b>4000 Forest Hill Road</b> <b>Baltimore, Maryland 21207</b>		<b>Md. Balto.</b> <small>C. CITY OR TOWN (If outside city limits, write RURAL and give township)</small> <b>Baltimore</b> <small>D. STREET ADDRESS (If rural, give location)</small> <b>4000 Forest Hill Rd.</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>never married</b>	8. DATE OF BIRTH <b>Aug. 29, 1877</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lab. Technician</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Daughter of Charity</b>	9. AGE (In years last birthday) <b>89</b>
11. BIRTHPLACE (State or foreign country) <b>Boston, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rupert Yendley - Boston, Mass.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Holland - New Brunswick, Canada</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Sister Andrea, 4000 Forest Hill Rd.</b>		ADDRESS	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>General arteriosclerosis?</b> DUE TO <b>14 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 1952</b> to <b>Sept. 1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Sept. 27, 1966</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED <b>Sept. 28, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Damian P. Alagia</b>		23D. ADDRESS <b>3326 Frederick Avenue</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/30/66</b>	
24C. NAME of CEMETERY or CREMATORY <b>St. Joseph's</b>		24D. LOCATION (City, town, or county) (State) <b>Emmitsburg - Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>Stewart &amp; Mowen Co. - Balto-Md.</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09877	
BIRTH NO. 66 09877		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Phillips, Mrs. Grace R.</i>		2. DATE AND HOUR OF DEATH <i>9-30-66 4:45 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Carroll</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Sykesville 56-00</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>Mineral Hill Road</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOW</i>	8. DATE OF BIRTH <i>1-27-79</i>	9. AGE (In years lost birthday) <i>87</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Bell, George</i>		14. MOTHER'S MAIDEN NAME <i>Mason, Frances</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>MR. CARROLL Phillips - Sykesville, Md.</i>	
18. <i>446X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Uremia</i> DUE TO (B) <i>Dehydration</i> DUE TO (C) <i>Gen. Arteriosclerosis, Nephrosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>9-29 1966</i> to <i>9-30 1966</i> , that (we) last saw the deceased alive on <i>9-29 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jose A. Palancar</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9-30-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOSE A. PALANCAR</i>		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10-3-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Old OAKland Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Sykesville, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 3 1966</i>			
25B. NAME OF REGISTRAR <i>John E. Feltner</i>		25C. FUNERAL DIRECTOR <i>Harry W. Knight</i>			
25D. ADDRESS <i>Sykesville, Md.</i>					

THE A. H. HARRIS  
HARRIS

x

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09878		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09878	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOHN Wills DAVIS</b>		2. DATE AND HOUR OF DEATH <b>Sept 26/1966 10.44 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Goulds Nursing Home 6116 Belair Rd.</b>		A. STATE <b>Maryland</b>		B. COUNTY <b>25-04</b>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>122 Patapsco Ave.</b>			
5. SEX <b>M.</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. ?, 1890 75</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chipper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Ship Yard</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Reuben Davis</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Saunders</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Mary Ruth King, Baltimore, Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>422.1 I</b>		CAUSE OF DEATH <b>Cerebrovascular Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>one day.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <b>generalized Arterio Sclerosis</b>			
		(B) DUE TO <b>A.S.C.V. Disease with R.B.B.B.</b>		<b>years</b>	
		(C) <b>Paralysis Agitans</b>		<b>years.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Aug 11</b> 19 <b>66</b> to <b>Sept 26</b> 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Sept 26</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Atollah Golpira</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Sept 26/1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>ATAOLLAH GOLPIRA</b>		23D. ADDRESS <b>1942 Cedar Lane, Balto, Md. 21222</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/1/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Antioch Church</b>	
24D. LOCATION (City, town, or county) (State) <b>Orange County, Virginia</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		25B. NAME OF REGISTRAR <b>W. C. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>W. C. Johnson, Locust Grove, Va.</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 09879</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>66 09879</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ROBERT S. DOYLE</b>		2. DATE AND HOUR OF DEATH <b>9-28-66 10.25 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		D. STREET ADDRESS (If rural, give location) <b>633 REGESTER AVE 21212</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10-25-16</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Research Chemist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Davidson Chem. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>LOUIS DOYLE</b>			
14. MOTHER'S MAIDEN NAME <b>ETHEL CARPENTER</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes W.W.II</b>			
16. SOCIAL SECURITY NO. <b>579-14-7096</b>		17. INFORMANT ADDRESS <b>Mrs. Betty Doyle 633 Regester Ave.</b>			
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>200.0 I</b>		(A) <b>pulmonary edema</b> DUE TO		<b>20 min</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>thrombocytopenia</b> DUE TO		<b>approx 5 days</b>	
		(C) <b>reticulum cell sarcoma</b>		<b>approx 1 year</b>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>no</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>7:45 AM 28 Sept 1966</b> to <b>10:25 PM 28 Sept 1966</b> , that (we) last saw the deceased alive on <b>10:25 PM 28 Sept 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Daniel C. Hadlock</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>28 Sept. 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>DANIEL C. HADLOCK</b>		23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/3/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Arlington National</b>	
24D. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Rd Baltimore, Maryland 21212</b>			







7/10/1915  
10/10/1915  
10/10/1915

Atkins

Atkins General Hosp

White

George A. Dost

No.

George A. Dost

Bessie Lewis

Atkins

White

Atkins

Atkins

White

Atkins

Atkins

George A. Dost

White

Atkins General Hosp

Atkins

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09881		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09881	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Mose McDuffie.</i>		2. DATE AND HOUR OF DEATH <i>9/26/66</i> <i>8:40</i> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>18-02</i>			
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lincoln Memorial Nursing Home</i> <i>27 N. Carey St</i> <i>Baltimore, Md. 21223</i>		6. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
7. STREET ADDRESS (If rural, give location) <i>27 N. CAREY ST.</i>		8. DATE OF BIRTH <i>12/20/88</i>		9. AGE (In years lost birthday) <i>78</i>	
10. SEX <i>M</i> 11. RACE <i>N</i> 12. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i>		13. DATE OF BIRTH		14. AGE (In years lost birthday)	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY		17. BIRTHPLACE (State or foreign country)	
18. FATHER'S NAME <i>UNKNOWN.</i>		19. MOTHER'S MAIDEN NAME <i>UNKNOWN.</i>		20. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		22. SOCIAL SECURITY NO. <i>218-01-2127</i>		23. INFORMANT ADDRESS	
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>443 X I</i> <i>Cerebral Hemorrhage</i>		25. CAUSE OF DEATH (A) DUE TO <i>Cerebral Hemorrhage</i> (B) DUE TO <i>Hypertensive Cardiovascular Disease</i> (C) _____		26. INTERVAL BETWEEN ONSET AND DEATH	
27. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
29. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2/19/1959</i> to <i>Sept. 26</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Sept. 26</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Harris Tennarine</i>		23B. DATE SIGNED <i>9/27/66</i>			
23C. PHYSICIAN'S NAME (Type) <i>HARRIS TENNARINE</i>		23D. ADDRESS <i>930 WINTEROCK ST, BAL 17</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-1-1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Bklyn, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 3 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Chas. W. Hill Funeral Home</i>		25D. ADDRESS <i>1317 W. North Ave</i>			

William Hemminger  
William Hemminger

No

4/1/42

Wm Hemminger  
Wm Hemminger

4/1/42  
for number 21, for

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Certificate of Death		Registered No. <b>66 09882</b>	
BIRTH NO. <b>66 09882</b>				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>JOSEPH FRANK GANGE</b>				2. DATE AND HOUR OF DEATH <b>SEPTEMBER 29, 1966 1:40 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>23-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>FRANKLIN SQUARE HOSPITAL</b> <b>36 BALTIMORE, MD.</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>1430 S. LIGHT ST., 30</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M, D</b>	8. DATE OF BIRTH <b>NOVEMBER 20, 1906</b>	9. AGE (In years lost birthday) <b>59</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOE MAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SAME - DAN BROS.</b>		11. BIRTHPLACE (State or foreign country) <b>TEXAS, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK GANGE</b>				14. MOTHER'S MAIDEN NAME <b>LUCRECIA PERRICA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-03-7408</b>		17. INFORMANT <b>CHART, HOSPITAL</b>		ADDRESS	
18. <b>153.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE PULMONARY EDEMA</b> <b>SEVERE BILATERAL COMPLICATING NUTRITIONAL CIRRHOSIS, SEVERE</b> <b>OA OF SIGMOID &amp; DISTANT METASTASIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <b>(217-03-1100)</b>		INTERVAL BETWEEN ONSET AND DEATH	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>3 9-7-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Colon Resection</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9-2-66</b> 19 to <b>9-29-66</b> 19, that (I) (we) last saw the deceased alive on <b>9-29-66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Ferdinand C. Rodriguez</b>				M.D. Attending Physician <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Physician <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/29/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ferdinand C. Rodriguez</b>				23D. ADDRESS M.D. <b>Franklin Square Hosp. Balto. Md.</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/3/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda Inc. Hudson St. &amp; Linwood Ave. Balto. Md.</b>			

ON 20th Nov 1944  
at 10.15 AM  
at 10.15 AM  
at 10.15 AM  
at 10.15 AM  
at 10.15 AM



1  
L 535

66 09883

BALTIMORE CITY HEALTH DEPARTMENT

66 09883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
Charles Lindner		October 1st 1966 8:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland	
00 720 West Baltimore St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 4-02	
		D. STREET ADDRESS (If rural, give location) 720 West Baltimore St.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-22-07
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Cemetery	9. AGE (In years last birthday) 59
11. BIRTHPLACE (State or foreign country) Tenn		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fred Lindner		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Katherine Lindner		ADDRESS Above	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 163X I Carcinoma of Lung		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
Werner U. Spitz, M.D.		DATE SIGNED Oct 1st 66	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	
Burial 10-4-66		23C. NAME OF CEMETERY or CREMATORY London Park	
23D. LOCATION (City, town, or county) (State) Baltimore Md.		24A. DATE REC'D BY HEALTH DEPT. OCT 3 1966	
24B. NAME OF REGISTRAR Robert E. Farber, M.D.		24C. FUNERAL DIRECTOR John J. Corvan & Sons Inc.	
		ADDRESS Baltimore Md.	

MEDICAL CERTIFICATION



*Chrysomelidae*

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BILLY

H.

SHARPE

2. DATE AND HOUR PRONOUNCED DEAD

September 28, 1966

10:54 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 48 Market Place

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

48 Market Place

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

8/25/19

9. AGE (In years  
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.  
Months; Days Hours Min.

1

3

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Unemployed

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

James R. Sharpe

14. MOTHER'S MAIDEN NAME

Mary L. Deitz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW1

16. SOCIAL  
SECURITY NO.

244-05-6791

17. INFORMANT

Wife

ADDRESS

1902 Amherst Rd.

Callie Sharpe

Hyattsville, Maryland

18.

E90491

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

n (A) Subdural Hematoma.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Unknown

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Unknown

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

9

?

'66

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Probable fall.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/29/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/3/66

23C. NAME of CEMETERY or CREMATORY

Parklawn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Rockville, Maryland

24A. DATE REC'D BY HEALTH DEPT.

OCT 3 1966

24B. NAME OF REGISTRAR

Robert E. Fidler

24C. FUNERAL DIRECTOR

Pumphrey Funeral Home, Rockville, Md.

WALTER  
1911  
1912  
1913  
1914  
1915

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

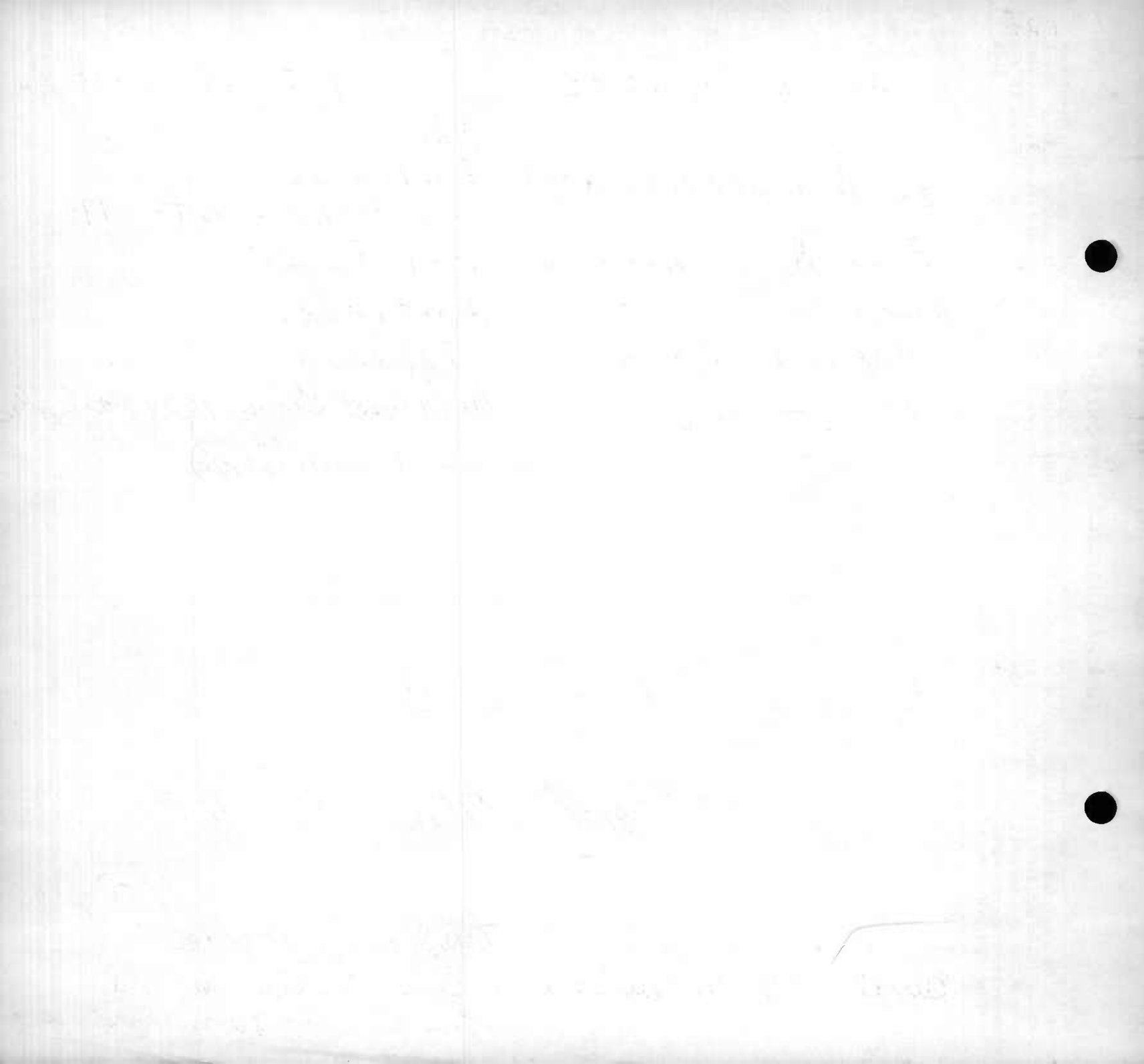
Baltimore City Health Department				Registered No.	
BIRTH NO.		66 09885		66 09885	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		MEISTER, IDA (IDA ESTELLA MEISTER)		2. DATE AND HOUR OF DEATH 1 Oct. 66 10 pm M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY Baltimore Maryland			
37 Mercy Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, 11-02			
		D. STREET ADDRESS (If rural, give location) Mid Town Nursing Home - St. Paul St.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) (Divorced) Widow	B. DATE OF BIRTH 1877 March 7 - 1897	9. AGE (In years lost birthday) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Clerk		10B. KIND OF BUSINESS OR INDUSTRY Retail Sales		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME William Albrecht		14. MOTHER'S MAIDEN NAME Katherine Fletch		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 2-7-24-6349		17. INFORMANT: Son Mr. Ernest L. Meister, 2512 Hermosa Av., City	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, arising rise to the above cause (A) signaling the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Pulmonary edema, Conges- tive Heart failure (B) DUE TO - (Femoral neck fracture) - Erys		INTERVAL BETWEEN ONSET AND DEATH 18 hrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 8:30 23 19 66 to 1 Oct. 19 66, that (1) (we) last saw the deceased alive on 1 Oct. 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Vicente R. Carag Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1 Oct. 66	
23C. PHYSICIAN'S NAME (Type) VICENTE R. CARAG JR.		23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 10/3/66		24C. NAME of CEMETERY or CREMATORY Green Mount Crematory	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. OCT 3 1966			
24F. NAME OF REGISTRAR Robert E. Taylor, M.D.		24G. FUNERAL DIRECTOR Stewart & Mowen Co., 108 W. North Av., City			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09886</b>	
BIRTH NO. <b>66 09886</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Gibson, FRANCES</b>		2. DATE AND HOUR OF DEATH <b>9/30/66 3:25 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>—</b>		14-02	
FULL NAME OF HOSPITAL OR INSTITUTION <b>34 BON SECOURS Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		D. STREET ADDRESS (If rural, give location) <b>513 Mosher St - 17</b>	
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9-24-08</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>GARNER - FRED</b>		14. MOTHER'S MAIDEN NAME <b>THERESA ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Mr. Ernest Garner</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>170X I</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Carcinoma of Breast (pulmonary metastasis)</b> (B) <b>—</b> (C) <b>—</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? If in Baltimore City, give exact location	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/18/66</b> to <b>9/30/66</b> that (I) (we) last saw the deceased alive on <b>9/29/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Hun Kim</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9/30/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Hun Kim</b>		23D. ADDRESS M.D. <b>BON SECOURS Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct 5 1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cem</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		24F. NAME OF REGISTRAR <b>Paul E. Falek</b>	
24G. FUNERAL DIRECTOR <b>Earl Simon</b>		24H. ADDRESS <b>1827 W. NORTH AVE</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09887</b>	
BIRTH NO. <b>66 09887</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Salvatore Milio</b>			2. DATE AND HOUR OF DEATH <b>September 29 1966</b> <b>7:40 P. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>912 Eastern Ave</b> (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>3-02</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>912 Eastern Ave</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>June 13 1890</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	11. BIRTHPLACE (State or foreign country) <b>Patti Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Luigi Milio</b>			14. MOTHER'S MAIDEN NAME <b>Gaetana D'Antoni</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT ADDRESS <b>Teresa Milio (Wife) 912 Eastern Ave.</b>		
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Metastasis of malignancy of mouth with April 1965</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(A) DUE TO <b>metastasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>April 1965</b>
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 1966</b> to <b>9/29 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept. 29 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Israel J. Feinglos</b> M.D.			Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9/30/66</b>
23C. PHYSICIAN'S NAME (Type) <b>ISRAEL J. FEINGLOS</b> M.D.			23D. ADDRESS <b>2002 E PRATT ST Balto Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/3-1966</b>	24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>4430 Belair Rd. Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Frank J. Bellows 322 S. High St.</b>	



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09888				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09888	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>KINDRED, AUDREY MARIE</b>				2. DATE AND HOUR OF DEATH <b>SEPT 30 1966 340 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY HOSPITAL</b>		(If not in hospital or institution, give street address or location) <b>BALTIMORE Md.</b>		A. STATE <b>MARYLAND</b>		B. COUNTY <b>15-13</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>2806 SANTA FE AVE.</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>		8. DATE OF BIRTH <b>7-8-46</b>	9. AGE (In years last birthday) <b>20</b>	10. Under 1 Yr. Months <b></b>	11. Under 24 Hrs. Days <b></b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NA</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>NA</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>WILLIE KINDRED</b>			
14. MOTHER'S MARRIED NAME <b>Roselee Hoskin</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b></b>			
16. SOCIAL SECURITY NO. <b></b>				17. INFORMANT <b>WILLIE KINDRED</b>		ADDRESS <b>SAME</b>	
18. <b>034X I</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) <b>Cardiac Arrest</b>		<b>Sept. 30, 1966</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Congestive failure</b>		<b>Since May 66</b>	
				(C) <b>Myocardial Endocarditis</b>		<b>May 66</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20A. AUTOPSY? (Yes or No) <b>N</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b></b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NONE</b>			
21D. TIME OF INJURY (APPROX.) <b>NONE</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b></b>			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 23</b> 19 <b>66</b> to <b>Sept 30</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Sept 30</b> 19 <b>66</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Timothy Kenney Gray</b> M.D.						23B. DATE SIGNED <b>9-30-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>TIMOTHY KENNEY GRAY</b> M.D.						23D. ADDRESS <b>University Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Shipped</b>		24B. DATE <b>10-3-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Franklin Virginia</b>		24D. LOCATION (City, town, or county) (State) <b>Rayner Sanders 217 E. Preston St</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		25B. NAME OF REGISTRAR <b>R. E. Jones</b>		25C. FUNERAL DIRECTOR <b>Rayner Sanders</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

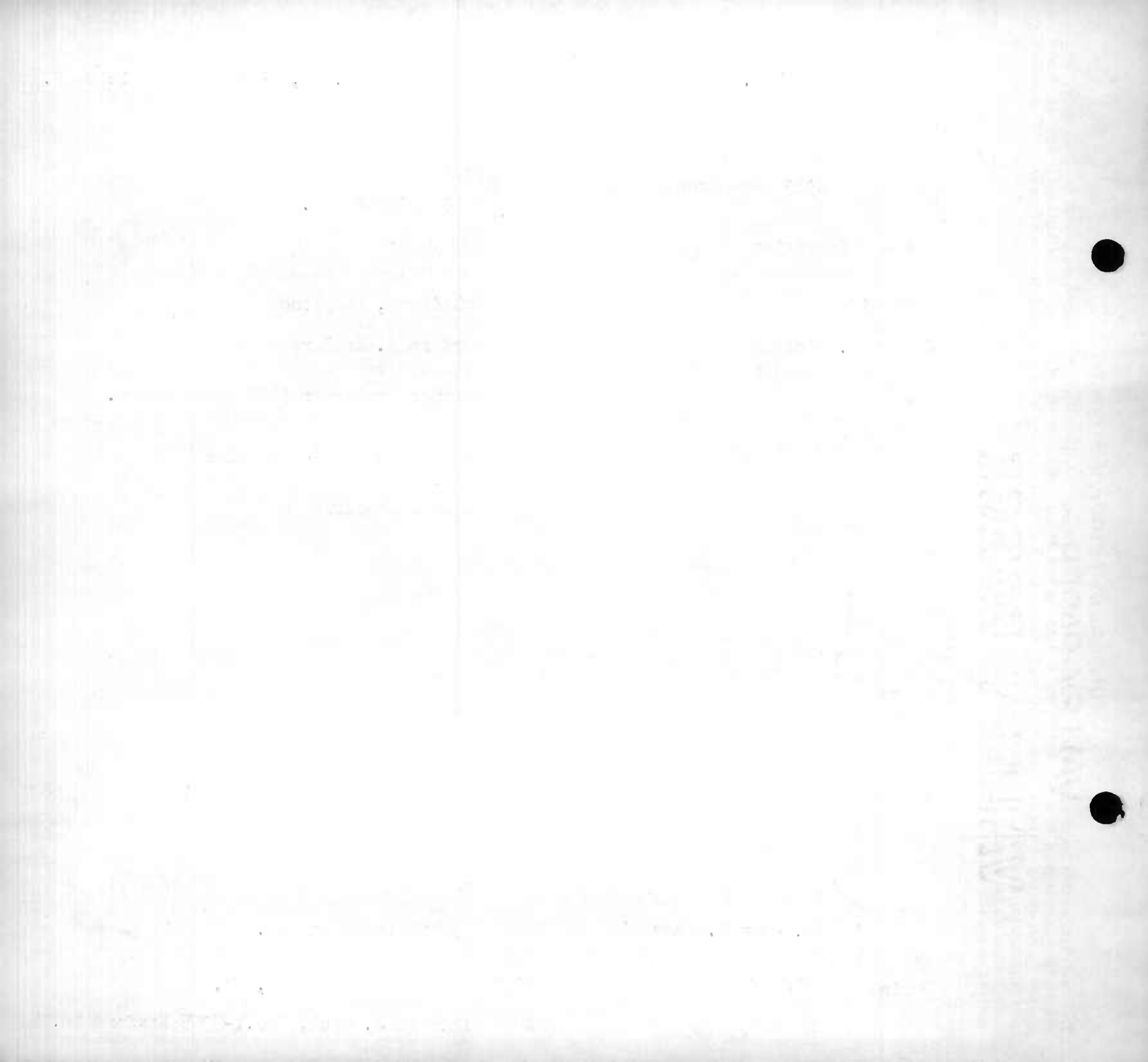
BIRTH NO. 66 098889		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 098889	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Joseph Hampton</i>		2. DATE AND HOUR OF DEATH <i>Sept 30, 1966 12:45 P M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>14-02</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lincoln Memorial Nursing Home</i> <i>27 N. Carey Street</i> <i>Baltimore, Md. 21223</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1631 PENNSYLVANIA AVE.</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>10-8-1900</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>	
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN-Sarah P</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>220-67-0486A</i>		17. INFORMANT ADDRESS <i>Lincoln Nursing Home</i>	
18. <i>493X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Pneumonia</i> DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Cellulitis of Scrotum.</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5-19</i> 19 <i>66</i> to <i>9-30</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9-30-66</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Harold Sennarline, M.D.</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>HAROLD SENNARLINE</i>		23D. ADDRESS <i>930 WHITEHALL ST, BALT, MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10-5-66</i>	24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn Cem Balt</i>		24D. LOCATION (City, town, or county) (State) <i>MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 3 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Rayner Sanders 517 E Preston St</i>	

Richard L. ...

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																
66 09890					Certificate of Death					Registered No. 66 09890						
BIRTH NO. 66 09890										M.E. CASE NO.						
1. NAME OF DECEASED (Type or Print) Elizabeth T. Freburger										2. DATE AND HOUR OF DEATH Sept. 17, 1966 2:10 P. M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hood Nursing Home 5313 Edmondson Avenue										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5405 Grindon Ave.						
5. SEX Female		6. RACE Caucasian		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 2/26/1882		9. AGE (In years lost birthday) 84		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Baltimore, Maryland					12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph A. Edelman										14. MOTHER'S MAIDEN NAME Barbara A. Zellers						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.		17. INFORMANT Charles Freburger 5405 Grindon Ave.					ADDRESS				
18. 4 22.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio Vascular DUE TO Disease - Acute Pulmonary Edema DUE TO DUE TO										CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) No					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 9/8 19 66 to 9/17 19 66, that (I) (we) last saw the deceased alive on 9/17 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																
23A. SIGNATURE <i>John H. Shaw</i> Dr. John H. Shaw										M.D. Attending <input checked="" type="checkbox"/> Phys. Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED 9/19/66	
23C. PHYSICIAN'S NAME (Type) Dr. John H. Shaw										23D. ADDRESS 5800 Edmondson Ave.						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 9/20/66		24C. NAME of CEMETERY or CREMATORY Moreland Memorial					24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. OCT 3 1966					25B. NAME OF REGISTRAR Robert E. Fisher					25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., -5305 Harford Rd.					ADDRESS	

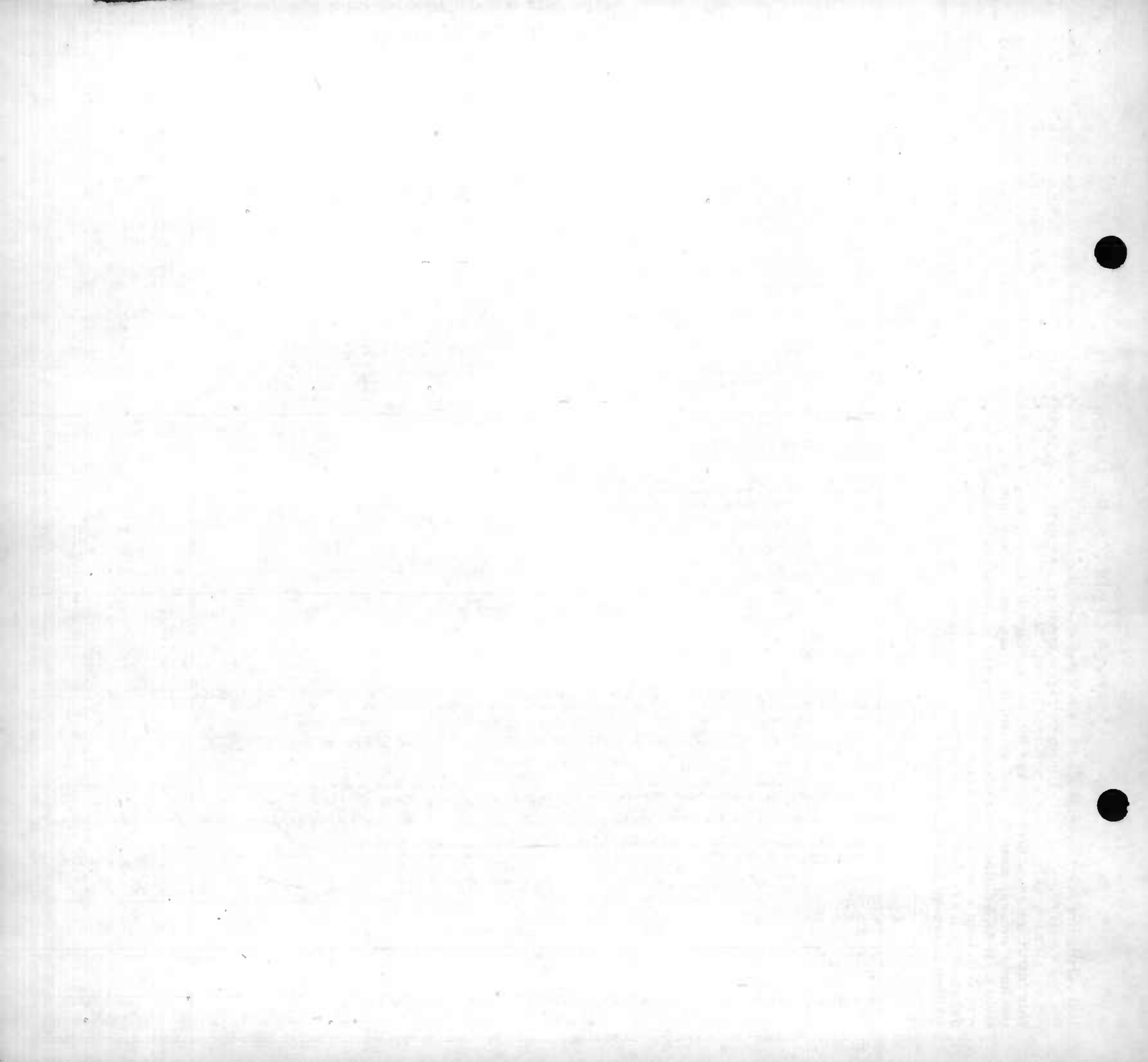


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 09891</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09891</b>	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Cora S. Scheferman</b>			2. DATE AND HOUR OF DEATH <b>10/1/66 8:05 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>37 Mercy Hospital Baltimore, Md.</b>			A. STATE <b>Md.</b> B. COUNTY <b>Balto. County</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>53-00</b>		
			D. STREET ADDRESS (If rural, give location) <b>1137 Granville Rd.</b>		
5. SEX <b>F</b>	6. RACE <b>Wh</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>8-12-92</b>	9. AGE (In years lost birthday) <b>74</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Harvey Bahr</b>			14. MOTHER'S MAIDEN NAME <b>Annie Edwards</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-38-1658</b>	17. INFORMANT <b>Mrs. Doris M. Pilson</b>		ADDRESS <b>5013 West Hills Rd.</b>
18. <b>7-20-1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Rupture of Myocardium</b> DUE TO (B) <b>Myocardial infarction</b> DUE TO (C) <b>ASCVD</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>7 days</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/1/66</b> to <b>10/1/66</b> , that (I) (we) last saw the deceased alive on <b>10/1/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Philip B. Drushin</b>				23B. DATE SIGNED <b>10/2/66</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-5-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Woodlawn Cem.</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Witzke F.D.-4101 Edmondson Av.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 09892		BALTIMORE CITY HEALTH DEPARTMENT		66 09892	
BIRTH NO.		<b>CERTIFICATE OF DEATH</b>		Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		RIDGELL, JAMES M.		2. DATE AND HOUR OF DEATH SEPTEMBER 29, 1966 5:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		25-41	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND 21229		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MARYLAND 21229		BALTIMORE		D. STREET ADDRESS (If rural, give location)	
3610 COOLIDGE AVENUE					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-10-15	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
DRUGGIST CLERK		PHARMACY		MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME James Ridgell (DEC'D)		14. MOTHER'S MAIDEN NAME Margaret Carroll (DEC'D)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) YES UNKNOWN		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS HOSPITAL SLIP - WILKENS & CATON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CERTIFICATION APPROVED BY CHIEF MEDICAL EXAMINER 9/30/66		CAUSE OF DEATH Renal Failure Exhaustive Burns Dehydration Renal Failure Exhaustive Body Burns	
INTERVAL BETWEEN ONSET AND DEATH 3 days		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3610 Coolidge Ave	
21D. TIME OF INJURY (APPROX.) 9/24/66 2:00 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Lawsire 25-41	
22. I certify that (X) (this hospital) attended the deceased from SEPT. 26, 19 66 to SEPT. 29, 19 66		that (X) (we) last saw the deceased alive on SEPT. 29, 19 66		and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Steve C. Papostephano		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/29/66	
23C. PHYSICIAN'S NAME (Type) STEVE C. PAPOSTEPHANO		23D. ADDRESS ST. AGNES HOSPITAL CATON AND WILKENS AVENUES 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-3-66		24C. NAME of CEMETERY or CREMATORY Baltimore National Cem. Baltimore, Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. OCT 3 1966		25B. NAME OF REGISTRAR Robert E. Jarky, M.D.	
25C. FUNERAL DIRECTOR Witzke F.D. - 4101 Edmondson Ave.		ADDRESS			

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FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>66 09893</b>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH <span style="font-size: 2em;">X</span>		Registered No. <b>66 09893</b>	
1. NAME OF DECEASED (Type or Print) <b>LOHMEYER, ELSIE E.</b>				2. DATE AND HOUR OF DEATH <b>9-30-66 3:40A M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>40 ST. AGNES HOSPITAL EMERGENCY ROOM</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto. County</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE ZONE 7</b> D. STREET ADDRESS (If rural, give location) <b>1174 ST. AGNES LANE 53-00</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>		8. DATE OF BIRTH <b>7-5-94</b>	9. AGE (In years lost birthday) <b>72</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HSWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES HUGGINS</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE OSSMUS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218524254</b>		17. INFORMANT ADDRESS <b>ST. AGNES RECORDS-CATON &amp; WILKENS AVES.</b>			
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Pulmonary Edema</b> DUE TO (B) <b>Idioventricular rhythm - Bradycardia</b> DUE TO (C) <b>Coronary Insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 30 1966</b> to <b>SEPTEMBER 30 1966</b> , that (I) (we) last saw the deceased alive on <b>SEPTEMBER 30 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9-30-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>EWALDO WEISS</b>				23D. ADDRESS M.D. <b>ST. AGNES HOSPITAL -CATON &amp; WILKENS AVE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-3-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>		25C. FUNERAL DIRECTOR <b>Witzke F.D.-4101 Edmondson Av.</b>		ADDRESS	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 09894</u>	
BIRTH NO. <u>66 09894</u>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		DATE AND HOUR OF DEATH <u>Sept. 30, 1966</u> <u>10:15 A.M.</u>	
1. NAME OF DECEASED (Type or Print) <u>Arthur M. Hahn</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>27-44</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>10-6-66</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
<u>00</u> <u>5931 Theodore Avenue</u>		D. STREET ADDRESS (If rural, give location) <u>5931 Theodore Ave.</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Divorced</u>	8. DATE OF BIRTH <u>1892</u> <u>Nov. 22, 1892</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. City</u>	9. AGE (In years lost birthday) <u>73</u>
13. FATHER'S NAME <u>William</u>		12. CITIZEN OF WHAT COUNTRY? <u>Balto. Md.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-03-5437</u>	17. INFORMANT <u>Miss Evelyn Hahn</u>
		ADDRESS <u>324 S. Castle St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Anteriodiclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) DUE TO (B) DUE TO (C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Diabetes Mellitus</u>	
19A. DATE OF OPERATION <u>10-6-66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>Sept. 30, 1966</u> , that (I) (we) lost saw the deceased alive on <u>Sept. 29, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Loy M. Zimmerman</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED <u>Sept. 30, 1966</u>
23C. PHYSICIAN'S NAME (Type) <u>Loy M. Zimmerman</u>		23D. ADDRESS <u>3202 Hartford Rd. Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Oct. 4 '66</u>	24C. NAME of CEMETERY or CREMATORY <u>Loudon Park</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 3 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>	25C. FUNERAL DIRECTOR <u>Witzke</u>
		ADDRESS <u>4101 Edmondson Ave.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09895		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09895	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>BLINCO, PAUL</b>		
2. DATE AND HOUR OF DEATH <b>9/29/66 1:15 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL 48</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>6-01</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO</b>		
			D. STREET ADDRESS (If rural, give location) <b>7 N. STREEPER ST.</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>12/14/02</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HELPER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BREWERY</b>		11. BIRTHPLACE (State or foreign country) <b>OHIO</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>THOMAS BLINCO</b>			14. MOTHER'S MAIDEN NAME <b>? ANNA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-5777</b>		17. INFORMANT <b>WIFE</b> ADDRESS <b>SXME</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)			(A) <b>Branchogenic Carcinoma Pathologic + radiologic</b>		
			(B) <b>ASCVD</b>		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>April 1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of lung</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/26 19 66</b> to <b>9/29 19 66</b> , that (I) (we) last saw the deceased alive on <b>9/29 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Donald L. Galdner</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>9/29/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MD General Hospital</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/3/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery Baltimore Maryland</b>	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber M.D.</b>		25C. FUNERAL DIRECTOR <b>Bernard G. Gaborowski</b> ADDRESS	



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

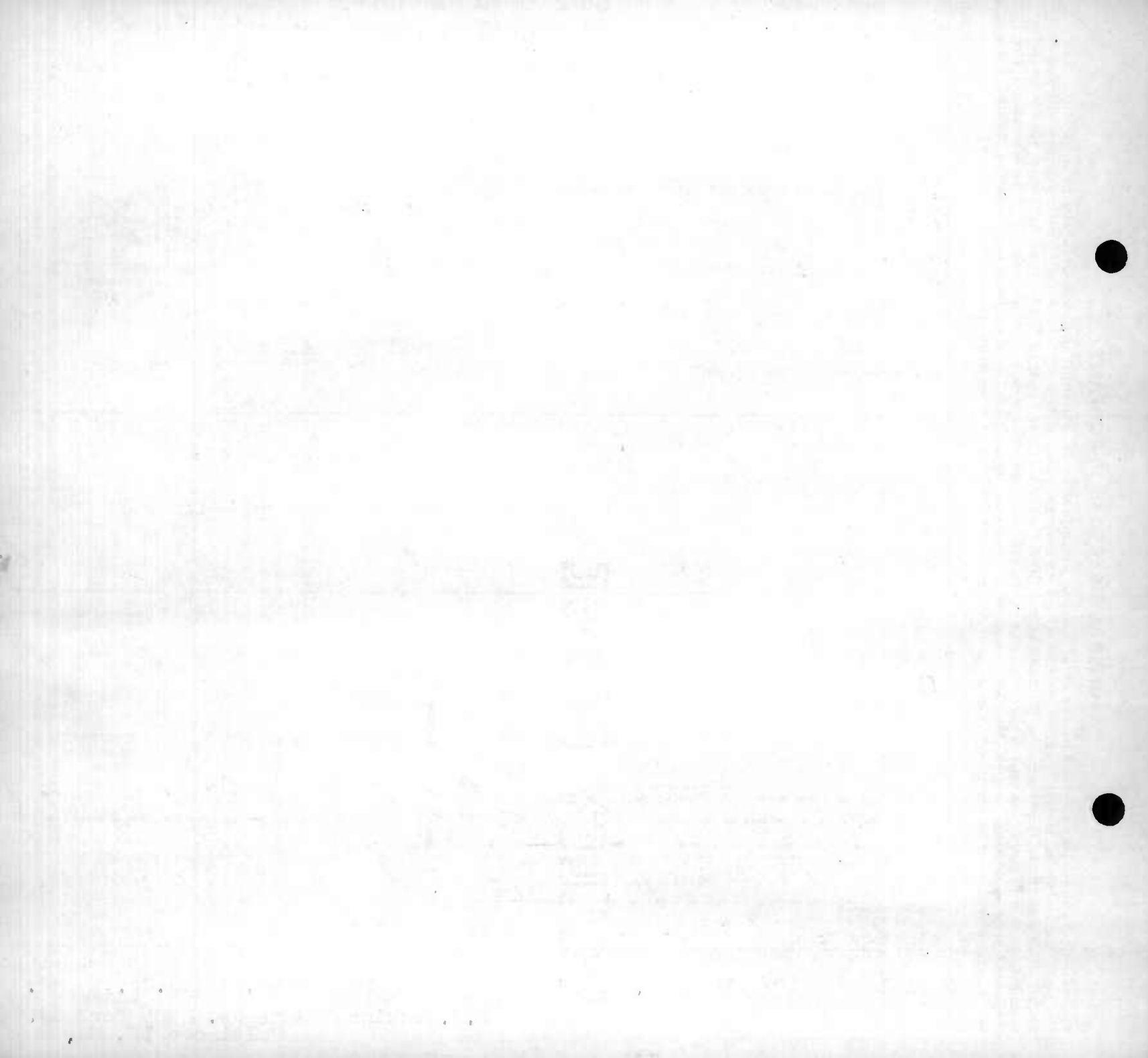
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09896</u>	
BIRTH NO. <u>66 09896</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Walter Allen</u>	
2. DATE AND HOUR OF DEATH <u>September 30, 1966</u>		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> <u>38</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>17-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>601 George Street</u>			
5. SEX <u>M.</u>	6. RACE <u>C.</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>Married</u>		8. DATE OF BIRTH <u>7/4/12</u>	9. AGE (In years last birthday) <u>54</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>John Allen</u>		14. MOTHER'S MAIDEN NAME <u>Belle Moss</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Martha J. Allen 601 George St.</u>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Myocardial Infarction</u> DUE TO (B) <u>General Atherosclerosis</u> DUE TO (C) <u>Arterio Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 1962</u> to <u>Sep 1966</u> , that (I) (we) last saw the deceased alive on <u>20 Sep 1966</u> and that in (my) <del>four</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Amr H. Carby</u>				23B. DATE SIGNED <u>3 Sept 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Amr H. Carby</u>				23D. ADDRESS M.D. <u>1207 Pennsylvania St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/11/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 3 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Charles A. Rice 661 W. Barre St.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 098897				BALTIMORE CITY HEALTH DEPT.		Registered No. 66 098897	
1. NAME OF DECEASED (Type or Print) Mrs. Agnes C. Heckrotte				2. DATE AND HOUR OF DEATH October 1 1966 7:00 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital 48		(If not in hospital or institution, give street address or location)		A. STATE MD.		B. COUNTY 27-38	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 10/5/94	
9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) BALTO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SCARFF				14. MOTHER'S MAIDEN NAME FLORENCE EMORY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215 22 2189		17. INFORMANT HUSBAND		ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Cerebral Thrombosis and Embolus DUE TO (B) Rheumatic and Arteriosclerotic CVD DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 16 days.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 19 65 to Oct 1 19 66, that (I) (we) last saw the deceased alive on Oct 1 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Lester A. Wall Jr.				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Oct 1, 1966	
23C. PHYSICIAN'S NAME (Type) LESTER A. WALL JR.				23D. ADDRESS M.D. 1039 St. Paul St 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/4/1966		24C. NAME OF CEMETERY or CREMATORY St. John's		24D. LOCATION (City, town, or county) (State) Longgreen, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 3 1966		25B. NAME OF REGISTRAR Robert E. Jarboe, M.D.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09898				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09898	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
WAREHEIM, ELMER NELSON SR.				Oct. 1, 1966 12 <sup>25</sup> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
444 Union Memorial Hosp.				MARYLAND		BALTIMORE	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				BALTIMORE TOWSON			
D. STREET ADDRESS (If rural, give location)				306 BROOK ROAD 53-00			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
M	W	M	12-23-03	62	MANAGER	MARYLAND	U. S. A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
MANAGER				PERSONNEL			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM E. WAREHEIM				IDA GROSS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				215-05-4715		MRS. MARTHA C. WAREHEIM (SAME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
163X I				CARCINOMA OF THE LUNG			
ANTECEDENT CAUSES				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Sept. 29 1966 to Oct. 1 1966, that (I) (we) last saw the deceased alive on Oct. 1 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Zoltan Zoltan Zoltan				Union Memorial Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/4/1966		Parkwood		Parkville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
Oct 3 1966		Robert E. Farber		H.W. Jenkins & Sons Co.		4905 York Road Balto. 12, Md.	

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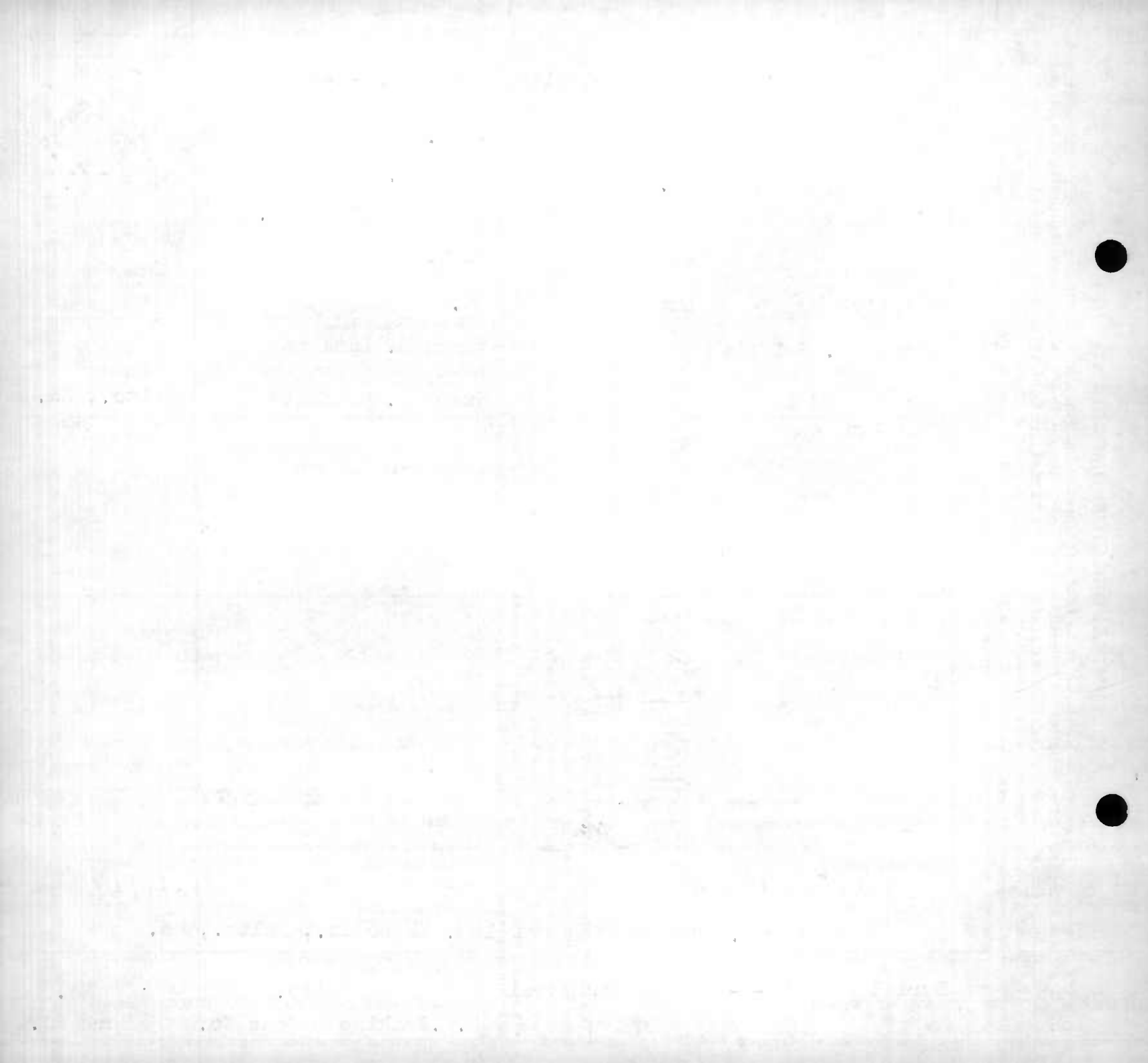
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09899	
BIRTH NO. 66 09899		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Edward Raymond Griffith		2. DATE AND HOUR OF DEATH 10-1-66 1 530 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 524 Woodlawn Rd.		A. STATE Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 524 Woodlawn Rd.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-14-85	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10B. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward A. Griffith			14. MOTHER'S MAIDEN NAME Emma L. Lanahan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Edward A. Griffith Balto., Md.	
18. 200.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Lymphosarcoma DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 65 to 19 66, that (I) (we) last saw the deceased alive on Sept 30 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter B. Buck				23B. DATE SIGNED 10/1/66	
23C. PHYSICIAN'S NAME (Type) Walter B. Buck				23D. ADDRESS M.D. 18E. Eager St., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-3-66		24C. NAME of CEMETERY or CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) Balto.		24E. (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. Oct 3 1966		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd.	





1  
C 455

66 09900

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09900

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>LOUIS Nicholas CLEMENS</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>September 29, 1966 2:15 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>112 E. 20th Street</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-04</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>112 E. 20th Street</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>5-16-1893</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>73</b>
13. FATHER'S NAME <b>John Clemens</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Bergen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) <b>Yes WW 1</b>		16. SOCIAL SECURITY NO. <b>218-32-2829</b>	
17. INFORMANT <b>J.R. Buffington-Att'y. Balto., Md.</b>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Diabetes Mellitus.</b>			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>9/29/66</b>			
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23B. DATE <b>10-4-66</b>	23C. NAME OF CEMETERY or CREMATORY <b>St. Josephs</b>	23D. LOCATION (City, town, or county) (State) <b>New Hampton Iowa</b>
24A. DATE REC'D BY HEALTH DEPT. <b>0013 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Faldut</b>	
24C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd. Balto., Md.</b>	

WALKER & PRICE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09901		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09901	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Mary B. Dolan			September 30, 1966 6:50 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF (If not in hospital or institution, give street and house or apartment number and locality) The Johns Hopkins Hospital			A. STATE Maryland B. COUNTY Baltimore		
5. SEX Female			6. RACE White		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married			8. DATE OF BIRTH 4/19/00		
9. AGE (In years last birthday) 66			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Warren Welch			14. MOTHER'S MAIDEN NAME Catherine Devereaux		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214-01-2519B		
17. INFORMANT V. Daniel J. Dolan			ADDRESS (Same)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) GRAM NEG SEPSIS UTI.			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21. MEDICAL CERTIFICATION					
22. I certify that (I) (this hospital) attended the deceased from 9/29/66 to 9/30/66, that (I) (we) lost saw the deceased alive on 9/30/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W Stan Wilson M.D.			23B. DATE SIGNED 9/30/66		
23C. PHYSICIAN'S NAME (Type) W Stan Wilson M.D.			23D. ADDRESS JHHT		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 10/3/1966		
24C. NAME OF CEMETERY or CREMATORY New Cathedral			24D. LOCATION Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. OCT 3 1966			25B. NAME OF REGISTRAR Robert E. Jenkins		
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					

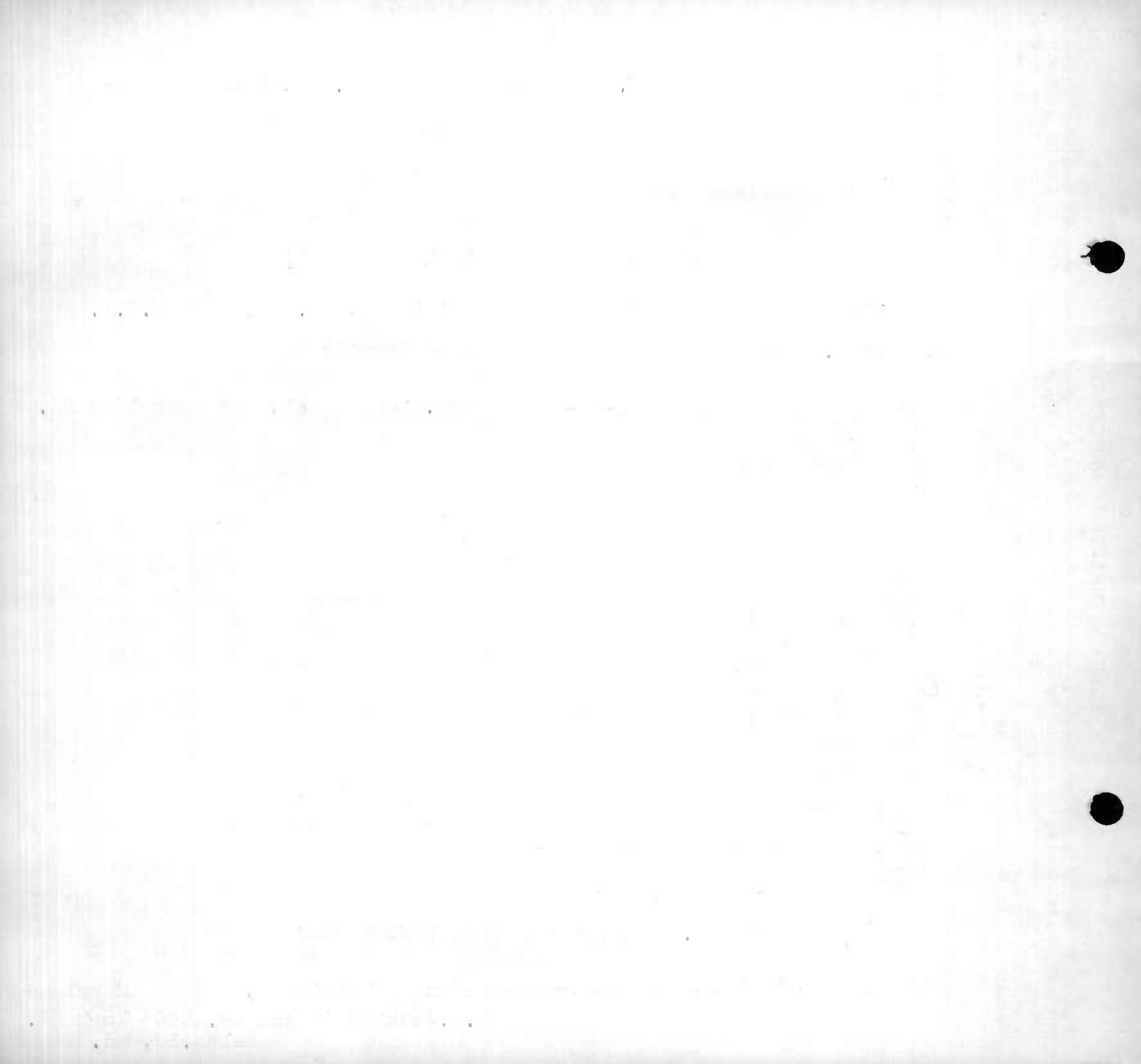
V.S. 153

10-13-66

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09902	
BIRTH NO. 66 09902				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Frances M. Lannon</b>			2. DATE AND HOUR OF DEATH <b>Sept. 27, 1966</b> <b>12 P.</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-48</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 608 Tunbridge Road</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>608 Tunbridge Road</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>4/11/1893</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Anthony P. Rice</b>			14. MOTHER'S MAIDEN NAME <b>Mary Schmidt</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-22-7685</b>	17. INFORMANT ADDRESS <b>Mrs. Harry Noel, 608 Tunbridge Rd.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <b>Myocardial infarction</b> <b>12 hrs</b> (B) <b>Arteriosclerotic heart disease</b> <b>20 yrs.</b> (C) <b>Arterial hypertension</b> <b>20 yrs</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 1946</b> to <b>Sept 27 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 27 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Frederick J. Vollmer</b> M.D.				23B. DATE SIGNED <b>9-29-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Frederick J. Vollmer</b> M.D.				23D. ADDRESS <b>6100 York Road</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/30/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Govans Presbyterian</b>	
24D. LOCATION <b>Baltimore,</b>		24E. LOCATION (City, town, or county) (State) <b>Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>	





R-300

66 09903

BALTIMORE CITY HEALTH DEPARTMENT

66 09903

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LENA

REDD

2. DATE AND HOUR PRONOUNCED DEAD

September 30, 1966

A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2800 W. Mulberry Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Sept. 20, 1896

9. AGE (In years  
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va  
Stafford County12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Pryor

14. MOTHER'S MAIDEN NAME

L. Pryor

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Rev. James Redd - 2800 W. Mulberry St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive and Arteriosclerotic  
Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/30/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Oct 4/66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

(City, town, or county)

(State)

D.C. County, Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 3 1966

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Frank T. Eickman 1129 N. Charles St.

ADDRESS





M 625

66 09904

BALTIMORE CITY HEALTH DEPARTMENT

66 09904

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
LOUISE MORRISON		September 30, 1966	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE New York	
Johns Hopkins Hospital		B. COUNTY N. Y.	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Ossining	
		D. STREET ADDRESS (If rural, give location)	
		3 Market Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Female	Negro	Single	Oct. 13, 1900
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
None			65
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Norfolk Va.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Morrison, Richmond		Sarah Draper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
			Oliver L. Nichols 3 Market Street

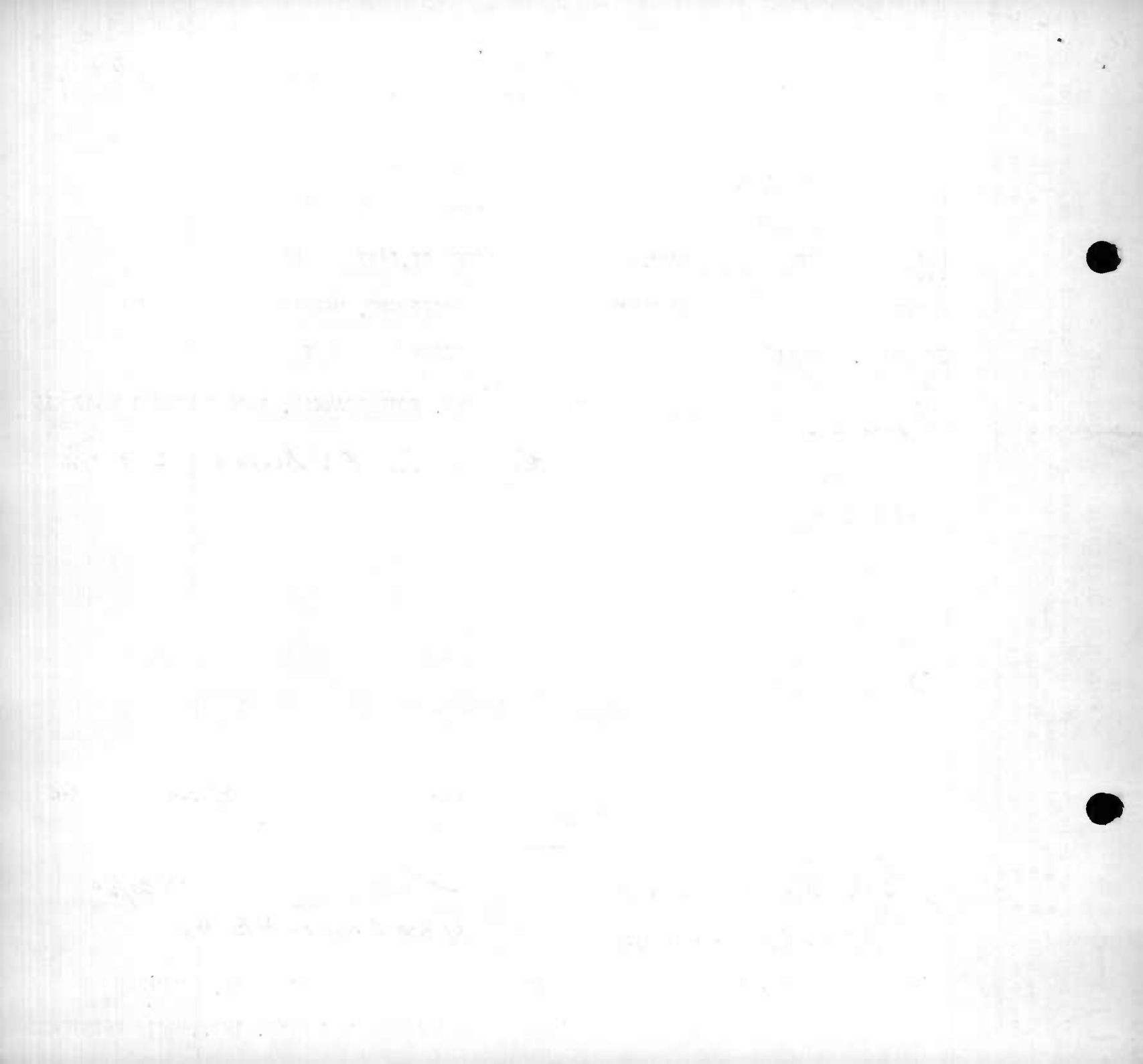
MEDICAL CERTIFICATION	18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		
	(A) Arteriosclerotic Cardiovascular Disease.		
	(B) DUE TO		
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
	19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
			No
	21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	9/30/66
Charles S. Petty, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Removal	Oct. 3/66		Ossining New York
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS	
OCT 3 1966		Milton E. Ellickson 1/2977 Carlyle St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 09905	
BIRTH NO. 66 09905										CERTIFICATE OF DEATH	
M.E. CASE NO.										2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Benjamin Frankle										Sept 29/66 3:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										A. STATE B. COUNTY	
3909 BANCROFT ROAD										MARYLAND	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)										BALTIMORE	
D. STREET ADDRESS (If rural, give location)										3909 BANCROFT ROAD	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
MALE		WHITE		MARRIED		MARCH 27, 1907		59			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
CUTTER				CLOTHING		BALTIMORE, MARYLAND				USA	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
JOSEPH M. FRANKLE						CLARA ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO						UNKNOWN		MRS. ROSE FRANKLE, 3909 BANCROFT ROAD #15			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)										(A) DUE TO	
ANTECEDENT CAUSES										(B) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1959 to 9/29/66 that (I) (we) last saw the deceased alive on 9/29/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE E.S. Kallins								M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/30/68	
23C. PHYSICIAN'S NAME (Type) EDWARD KALLINS								23D. ADDRESS M.D. 4300 LINCOLN HTS A			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
BURIAL				10/2/66		MOSES MONTIFIORO				BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
OCT 3 1966				Robert E. Taylor, M.D.				SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>66 09906</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09906</b>	
M.E. CASE NO.		1. NAME OF DECEASED <i>Rose Zvares</i>		2. DATE AND HOUR OF DEATH <i>Sept 29/66 11 30 A.M.</i>	
(Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>15-09</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sina Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>3021 Wolcott Ave</i>	
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		8. DATE OF BIRTH <i>March 10, 1887</i>	
13. FATHER'S NAME <i>Aaron Shocket</i>		14. MOTHER'S MAIDEN NAME <i>Leah?</i>		9. AGE (In years last birthday) <i>79</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-32-4388</i>		17. INFORMANT <i>Ruben Zvares</i>	
18. <i>443X1</i>		CAUSE OF DEATH		ADDRESS <i>3021 Wolcott Ave</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Hypertensive arteriosclerotic Vascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>25-30 yr</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Acute pulmonary edema Recurrent</i>		<i>2-3 yrs</i>	
(C) _____		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11-28-35</i> to <i>9-28-66</i> that (I) (we) lost saw the deceased alive on <i>9-23-66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Dr. Herman Seidel</i>		23B. DATE SIGNED <i>9-30-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>HERMAN SEIDEL</i>		23D. ADDRESS <i>2404 EUTAW PL-BALTO., MD</i>		23E. MED. DIRECTOR <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>10/2/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Worhamen Circle</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 3 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Sisk</i>	
25C. FUNERAL DIRECTOR <i>Sp. Leunon</i>		25D. ADDRESS <i>4120 E. 6010 East Rd</i>		25E. DATE <i>10/2/66</i>	



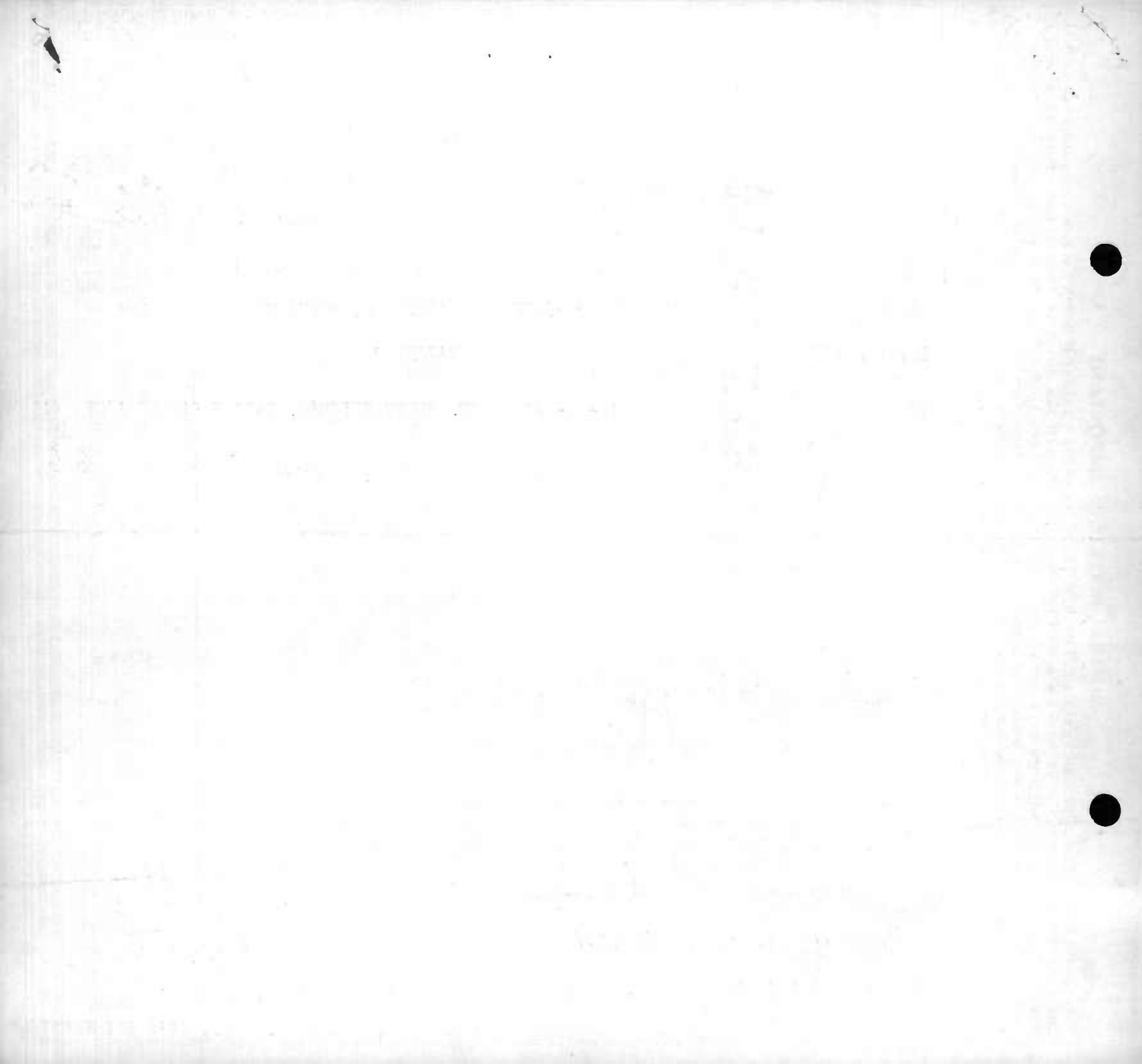


# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT														
66 09907					CERTIFICATE OF DEATH					Registered No. 66 09907				
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <i>Seidman-Lillian</i>				
2. DATE AND HOUR OF DEATH <i>9/29-1966 3 P M.</i>					3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTIMORE</i>				
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Smai Hospital</i>					(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 27-20</i>				
D. STREET ADDRESS (If rural, give location) <i>3320 Clarks Lane #15</i>					5. SEX <i>F</i> 6. RACE <i>W</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>m.</i>					8. DATE OF BIRTH <i>1/6/09</i> 9. AGE (In years lost birthday) <i>57</i>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CLERK</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>MAIL ORDER HOUSE</i>					11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MARYLAND</i>				
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					13. FATHER'S NAME <i>ISAAC CHAGT</i>					14. MOTHER'S MAIDEN NAME <i>SARAH ?</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>					16. SOCIAL SECURITY NO. <i>216-36-6828</i>					17. INFORMANT ADDRESS <i>MR. HENRY SEIDMAN, 3320 F CLARKS LANE #15</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) DUE TO <i>Metastatic carcinoma to brain 1966</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1950</i>				
					(B) DUE TO <i>Ca. of breast</i>									
					(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										19A. DATE OF OPERATION <i>1/9/28</i>				
										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>le thargy CNS signs</i>				
20A. AUTOPSY? (Yes or No) <i>NO</i>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date _____ and hour _____ and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <i>BARRY LINDENBAUM</i> M.D.										23B. DATE SIGNED <i>9/29</i>				
23C. PHYSICIAN'S NAME (Type) <i>BARRY LINDENBAUM</i> M.D.										23D. ADDRESS <i>SINAI Hospital</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>					24B. DATE <i>10/2/66</i>					24C. NAME OF CEMETERY OR CREMATORY <i>BETH TFILOH</i>				
24D. LOCATION <i>BALTIMORE, MARYLAND</i>					25A. DATE REC'D BY HEALTH DEPT. <i>OCT 3 1966</i>					25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>				
25C. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</i>										ADDRESS				





# FUNERAL DIRECTOR: IMPORTANT

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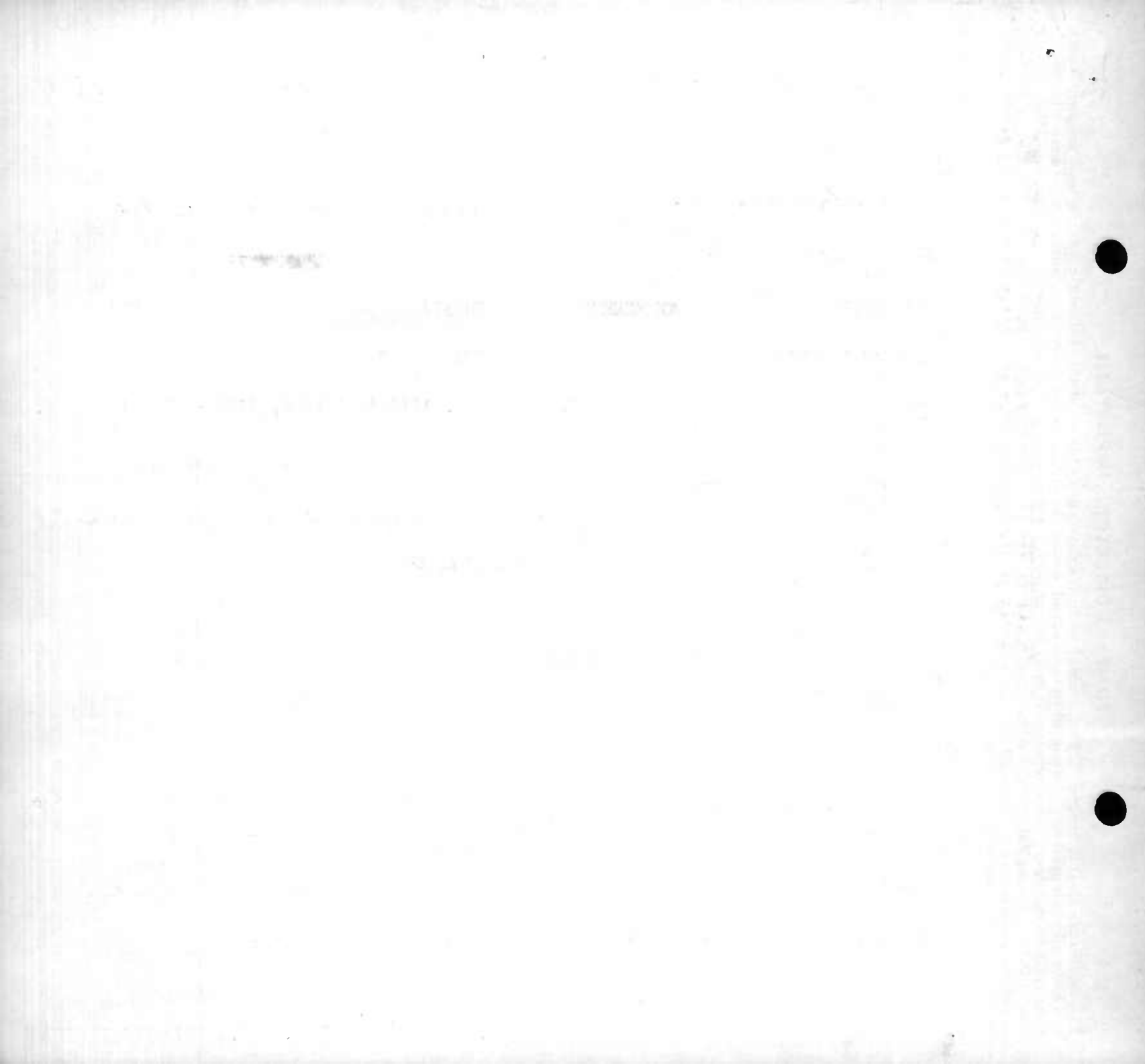
BIRTH NO. 66 09908		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09908	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LINA ZELLERMAYER		2. DATE AND HOUR OF DEATH SEPT. 30, 1966 7:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 3700 N. ROGERS AVENUE 10-13-66		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 27-19 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3700 N. ROGERS AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH MARCH 31, 1876	9. AGE (In years last birthday) 90	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? USA-GERMANY		13. FATHER'S NAME AARON LIPPMAN			
14. MOTHER'S MAIDEN NAME ESTHER MOTTEK XX		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. NO		17. INFORMANT MRS. ERNA KAUFMAN, 3700 N. ROGERS AVENUE			
18. 332 X 1 S.S.#216-48-4576 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis, general arteriosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1950 to Sept 29th 1966, that (I) (we) last saw the deceased alive on 9-29th 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harold H. Bix		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9-30th-66	
23C. PHYSICIAN'S NAME (Type) DR. HAROLD BIX		23D. ADDRESS M.D. 1401 REISTERSTOWN ROAD, PIKESVILLE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/2/66		24C. NAME OF CEMETERY or CREMATORY CHEVRA AHAVAS CHESED INC.	
24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. OCT 3 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 09909					CERTIFICATE OF DEATH		Registered No. 66 09909		
1. NAME OF DECEASED (Type or Print) <b>ANNA GILDEN</b>					2. DATE AND HOUR OF DEATH <b>9/30/66 10:45 A.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL OF BALTIMORE</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balti. County</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b> D. STREET ADDRESS (If rural, give location) <b>8120 SCOTTS LEVEL RD.</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>		8. DATE OF BIRTH	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>NATHAN FISHMAN</b>				14. MOTHER'S MAIDEN NAME <b>IDA ?</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT ADDRESS <b>MRS. LILLIAN LUTINS, 8120 SCOTTS LEVEL RD.</b>				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Pulmonary Edema</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Left myocardial infarction</b> <b>ASCVD</b>					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>9-30-66</b> 19 to <b>9-30</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>9/30/66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Gerardo Ypiz Jr</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/30/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>GERARDO YPIZ JR.</b>					23D. ADDRESS <b>SINAI HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/2/66</b>		24C. NAME of CEMETERY or CREMATORY <b>CHIZUK AMINO</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</b>				



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Baltimore City Health Department				Registered No.	
BIRTH NO.		66 09910		66 09910	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MAXIE ELLEN VAUGHN			September 30, 1966 12:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital			A. STATE MARYLAND B. COUNTY 12 07		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 11		
			D. STREET ADDRESS (If rural, give location) 2613 Miles Avenue		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days
FEMALE	White	Widowed	09-17-98	68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife			Virginia		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
SAM MESSER			SOLVIE UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				MR. WILLIAM H. VAUGHN SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) CEREBRAL THROMBOSIS		2 days
ANTECEDENT CAUSES			(B) ASCVD		? yrs.
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 29, 1966 to SEPTEMBER 30, 1966, that (I) (we) lost saw the deceased alive on SEPTEMBER 30, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
James W. Carthy, Jr. M.D.				9/30/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
James W. Carthy, Jr. M.D.		Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		10-3-66		Vaughn Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Duffield, Virginia		OCT 3 1966		Robert E. Farley, M.D.	
24G. FUNERAL DIRECTOR ADDRESS		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR	
1212 St Paul St Baltimore, Md.		Wm Cook - Brooks			

1915-1916

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1  
G. 626

66 09911

BALTIMORE CITY HEALTH DEPARTMENT

66 09911

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

JAMES

GREGORY

2. DATE AND HOUR PRONOUNCED DEAD

September 29, 1966 | 1:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2108 E. Baltimore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)  
Divorced

8. DATE OF BIRTH

Oct. 16, 1927

9. AGE (In years  
last birthday)

38 33

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

unknown

10B. KIND OF BUSINESS OR INDUSTRY

-----

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL  
SECURITY NO.  
unknown

17. INFORMANT

ADDRESS

Leavitt Funeral Home, Wadesboro, N.C.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Stab Wound of Chest.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

House

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

2122 E. Baltimore Street

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
9 29 '66 A

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed during altercation.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/29/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Oct. 3, 1966

23C. NAME of CEMETERY or CREMATORY

East View

23D. LOCATION

(City, town, or county)

(State)

Wadesboro, North Carolina

24A. DATE REC'D BY HEALTH DEPT.

OCT 3 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks, Inc. 1217 St. Paul St.  
Baltimore, Md. 21202

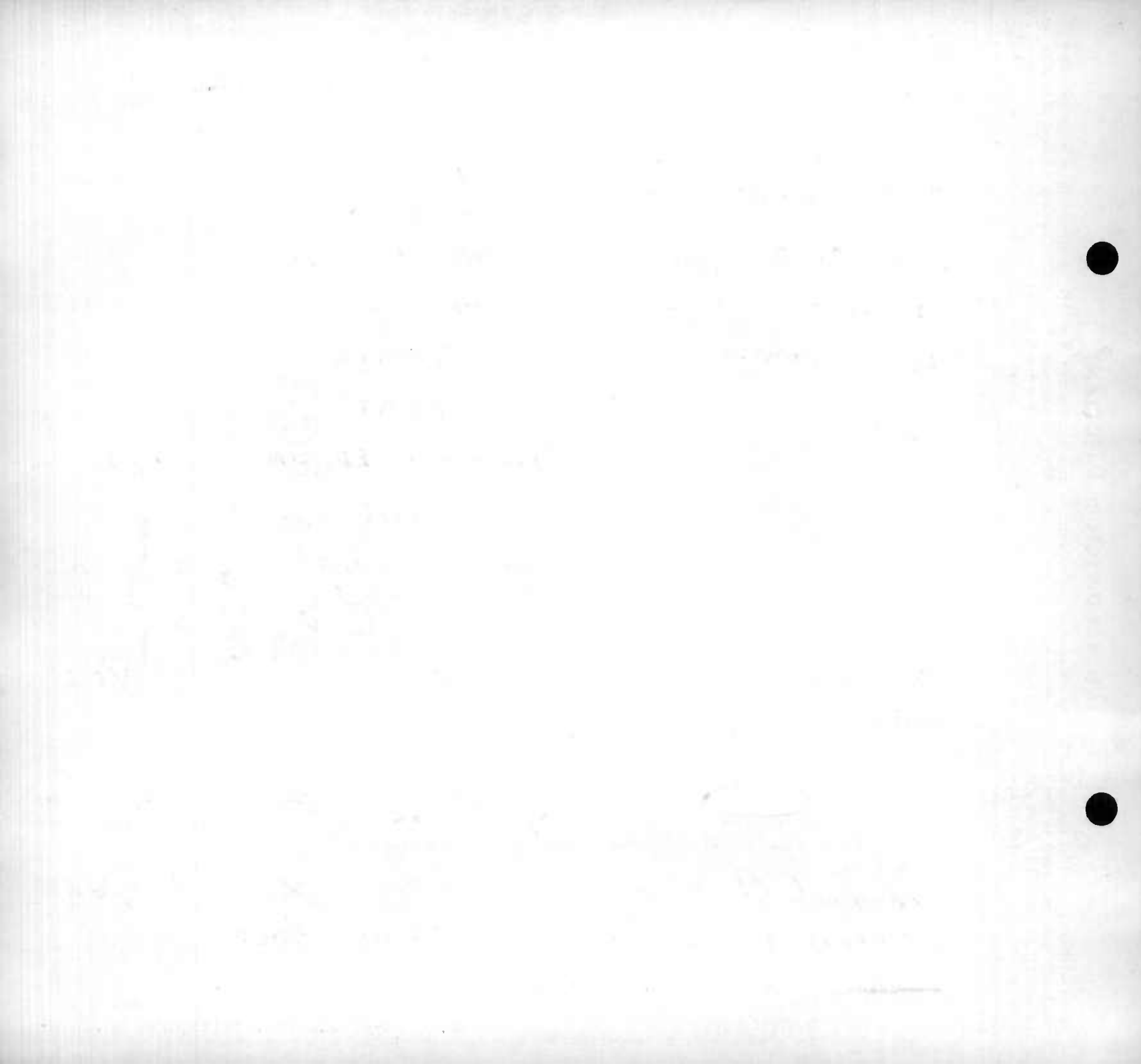


WALLINGTON

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

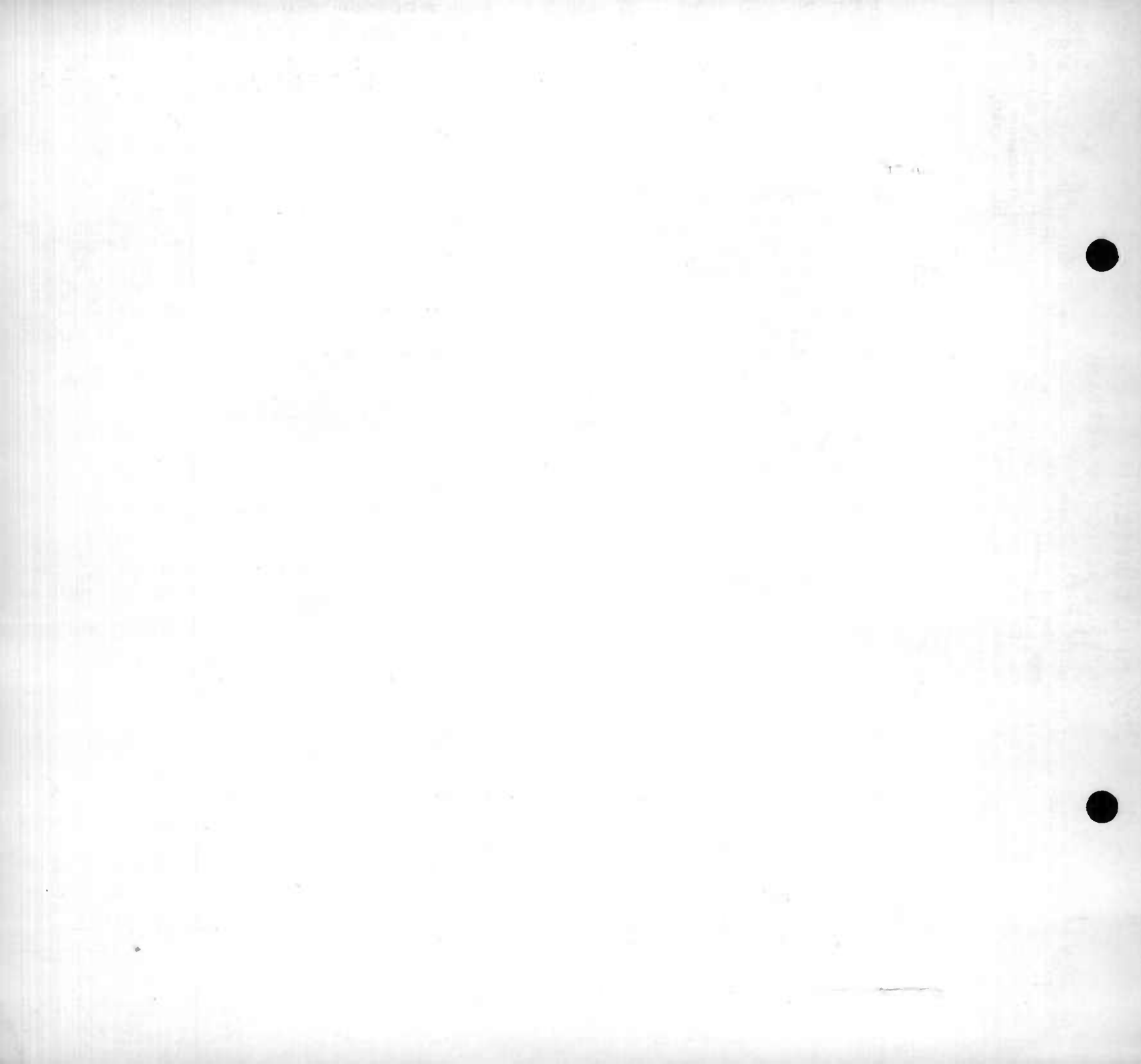
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09912</u>	
BIRTH NO. <u>66 09912</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JOSEPH A. HARTLE</u>		2. DATE AND HOUR OF DEATH <u>3:00 PM 10/1/66</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>USPHS HOSP BALTO. MD</u>		A. STATE <u>PENNSYLVANIA</u> B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>TIONESTA</u> V-35			
		D. STREET ADDRESS (If rural, give location) <u>RD 1 Box 77</u>			
5. SEX <u>MALE</u>	6. RACE <u>CAUC.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>7/22/47</u>	9. AGE (In years last birthday) <u>18</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>LEWIS HARTLE</u>		14. MOTHER'S MAIDEN NAME <u>GABLER</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>CHART</u>	
18. <u>178X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY EDEMA</u> INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u>		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>METASTASES FROM</u> DUE TO			
		(C) <u>CHORIOCARCINOMA</u> DUE TO		<u>MONTHS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>7/5</u> 19 <u>66</u> to <u>10/1</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/1</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael E. Pelczar</u> M.D.				23B. DATE SIGNED <u>10/2/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>MICHAEL E. PELCZAR</u> M.D.				23D. ADDRESS <u>USPHS HOSP.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/5/66</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Michael's</u>	
				24D. LOCATION (City, town, or county) (State) <u>Fryburg, Pa.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 3 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Inc. Baltimore, Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09913-33 A1 E0				CITY HEALTH DEPARTMENT		Registered No. 66 09913	
M.E. CASE NO. <u>Flounay</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Flounay, Addison, H</u>				2. DATE AND HOUR OF DEATH <u>October 166</u> <u>9-40</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u>		B. COUNTY <u>11-03</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>306 W. Franklin St.</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>		8. DATE OF BIRTH <u>01-06-83</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>that was Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A. American</u>	
13. FATHER'S NAME <u>Parke Poin dexter, Flounay</u>				14. MOTHER'S MAIDEN NAME <u>MARY MOORE SMITH</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>148-38-25-94-A</u>		17. INFORMANT <u>MR James Ridgely</u>	
18. <u>451X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Antecedent causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) CAUSE OF DEATH <u>Ruptured abdominal aortic aneurysm</u>		(B) DUE TO	
				(C) <u>Atherosclerosis</u>		(D) INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Sep. 13</u> 19 <u>66</u> to <u>Sep 31</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sep 31</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Sun young Choi</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Sep. 31 '66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. S un Young Choi</u> M.D.				23D. ADDRESS <u>The Union Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>cremation</u>		24B. DATE <u>10-3-1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>GREEN Mount</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 3 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Wm Cook-Brooks</u> ADDRESS <u>1217 St Paul St Baltimore Md</u>			



5.516

66 09914

BALTIMORE CITY HEALTH DEPARTMENT

66 09914

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

FLORENCE

SNOWBERGER

2. DATE AND HOUR PRONOUNCED DEAD

September 29, 1966 10:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1927 Sherwood Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1/31/93

9. AGE (In years  
lost birthday)

73

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

John R. Smith

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.  
None

17. INFORMANT

Family Records

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/30/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/3/66

23C. NAME of CEMETERY or CREMATORY

Druid Ridge Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, County Maryland

24A. DATE REC'D BY HEALTH DEPT.

OCT 3 1966

24B. NAME OF REGISTRAR

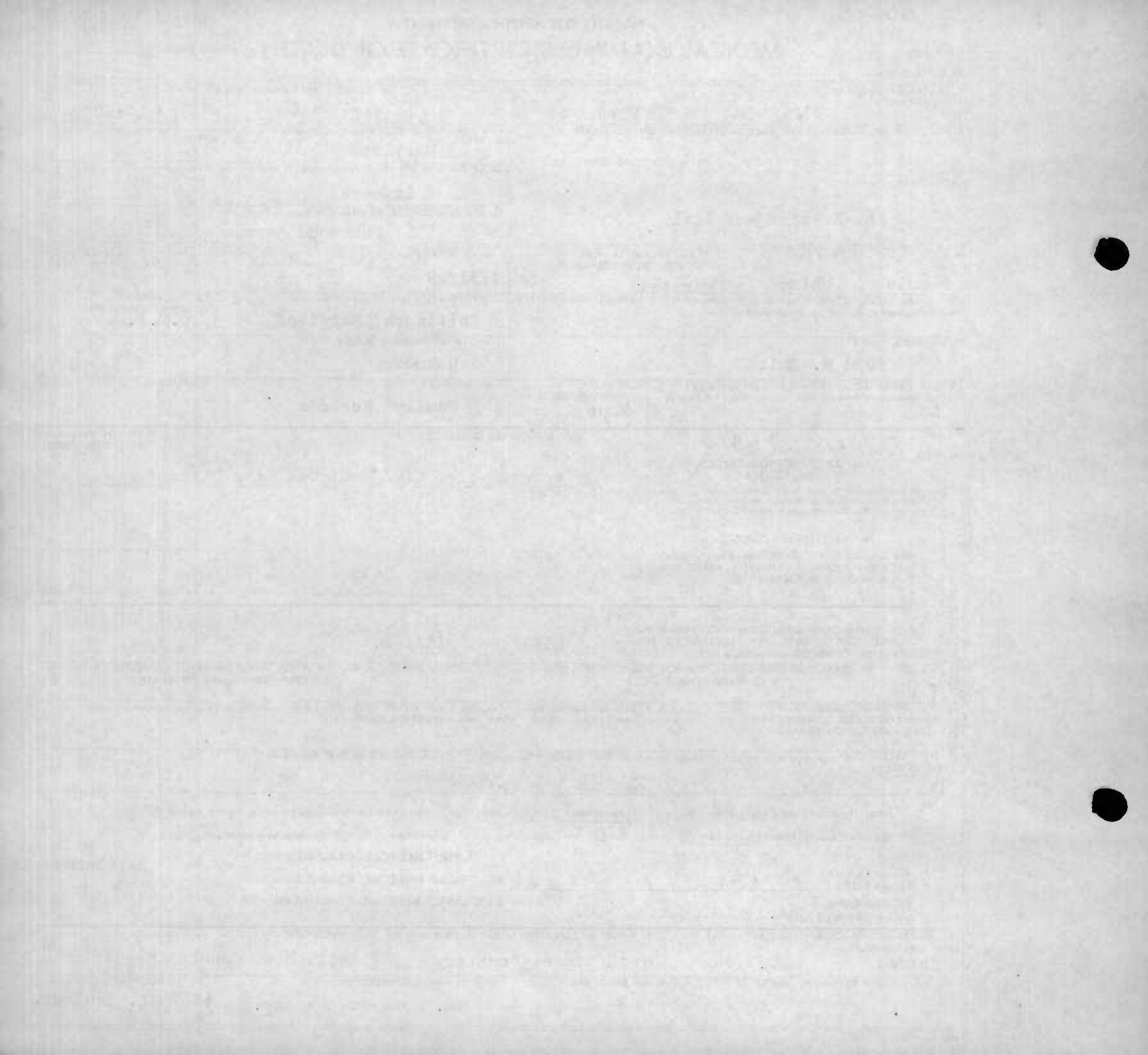
Robert E. Fedy

24C. FUNERAL DIRECTOR

WM. Cook-Brooks Inc.

ADDRESS

1217 St. Paul St.



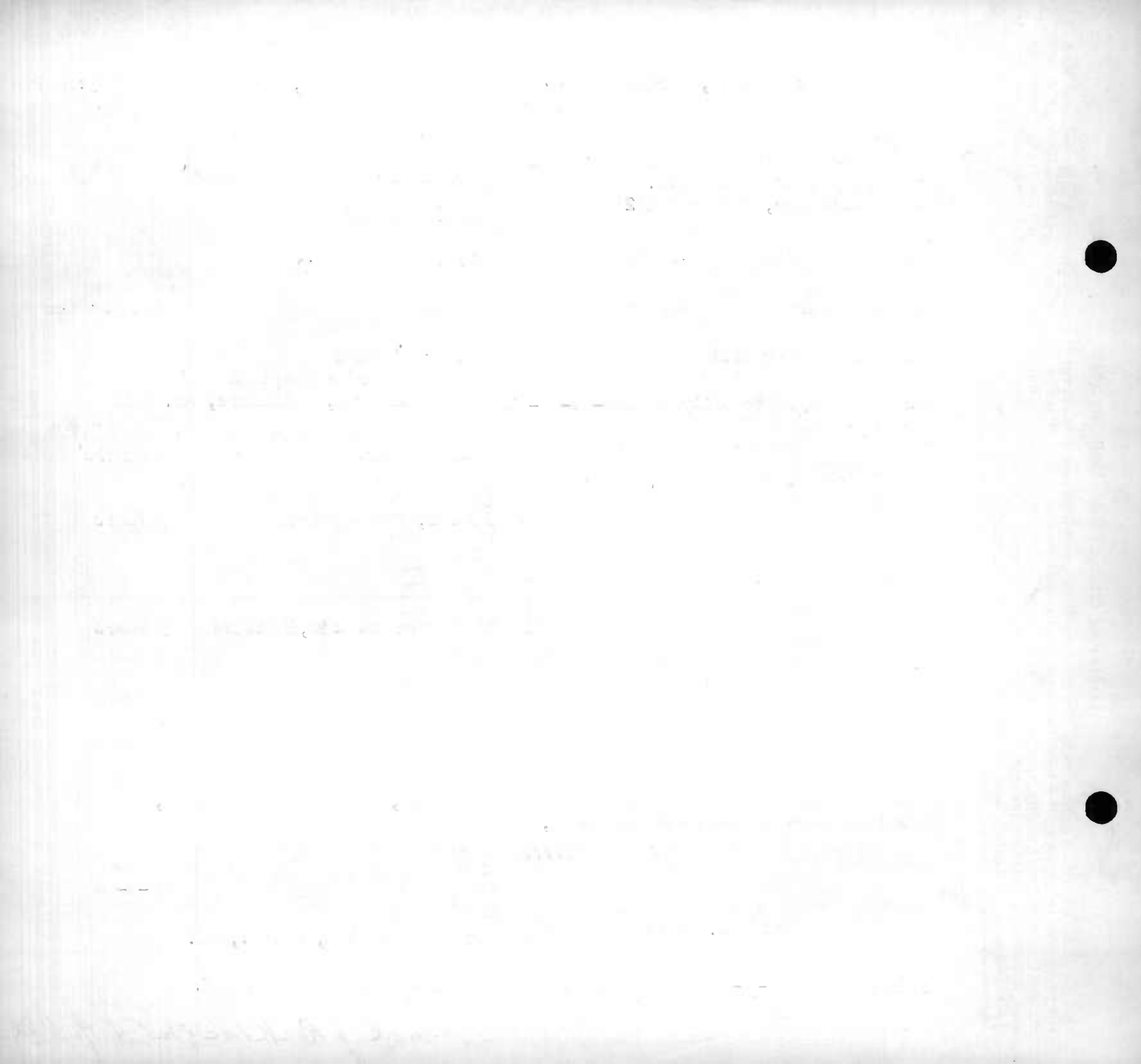


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>66 09915</b>		<b>CERTIFICATE OF DEATH</b>		66 09915	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Castagnetti, Tarquinio P.</b>		2. DATE AND HOUR OF DEATH <b>October 1, 1966 3:10 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-38</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Veterans Administration Hospital</b> <b>27 3900 Loch Raven Blvd. Baltimore, Maryland 21218</b>		D. STREET ADDRESS (If rural, give location) <b>1353 Northern Parkway</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>10/4/88</b>	9. AGE (In years lost birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone Carver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13. FATHER'S NAME <b>Alexander Castagnetti</b>		14. MOTHER'S MAIDEN NAME <b>Elvira Bacche</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 5/28/18 to 5/22/19</b>		16. SOCIAL SECURITY NO. <b>216-03-90-42A</b>		17. INFORMANT <b>Veterans Hospital</b> <b>Records, Baltimore, Md. 21218</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH Bronchogenic carcinoma with metastases</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 Months</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>II Pulmonary tuberculosis, inactive</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Years</b>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>September 27, 1966</b> to <b>October 1, 1966</b> , that (X) (we) last saw the deceased alive on <b>October 1, 1966</b> and that in (Xy) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) <b>view the body after death.</b>					
23A. SIGNATURE <b>Ralph H. Twining</b>				23B. DATE SIGNED <b>10-2-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ralph H. Twining</b>				23D. ADDRESS <b>Vettrans Hospital, Balto., Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>10-5-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Rock</b>		25D. ADDRESS <b>14c 5305 Harford Rd.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 09916	
BIRTH NO.				66 09916	
M.E. CASE NO.				66 09916	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
WURZBACHER, Frederick Ernst				10-1-66 2:10 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL 35 BALTIMORE, MD.				A. STATE MARYLAND B. COUNTY USA 27-38	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)	
BALTIMORE				5905 LOCH RAVEN BLVD.	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-28-90	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor & Builder			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN WURZBACHER			14. MOTHER'S MAIDEN NAME MARY HORSTMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-01-0149		17. INFORMANT Mrs. Ruth M. Wurzbacher
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO Coronary artery disease (B) DUE TO (C) Atherosclerosis, etc.		INTERVAL BETWEEN ONSET AND DEATH year
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-28-66 19 to 10-1-66 19, that (I) (we) last saw the deceased alive on 10-1-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. C. MARIANO				23B. DATE SIGNED 10-1-66	
23C. PHYSICIAN'S NAME (Type) J. C. MARIANO				23D. ADDRESS CHURCH HOME & HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/3/66		24C. NAME OF CEMETERY or CREMATORY Lorraine Pk. Mausoleum	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 3 1966			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214			

Washington, D.C. 20540

Dear Sirs:  
Enclosed are the 100 copies of the  
report on the work done during the  
past year.

Very truly yours,  
[Signature]

Enclosed are also 100 copies of the  
report on the work done during the  
past year.

Very truly yours,  
[Signature]

Enclosed are also 100 copies of the  
report on the work done during the  
past year.

Very truly yours,  
[Signature]

Enclosed are also 100 copies of the  
report on the work done during the  
past year.

Very truly yours,  
[Signature]

Enclosed are also 100 copies of the  
report on the work done during the  
past year.

Very truly yours,  
[Signature]

Enclosed are also 100 copies of the  
report on the work done during the  
past year.

Very truly yours,  
[Signature]

Enclosed are also 100 copies of the  
report on the work done during the  
past year.

Very truly yours,  
[Signature]

Enclosed are also 100 copies of the  
report on the work done during the  
past year.

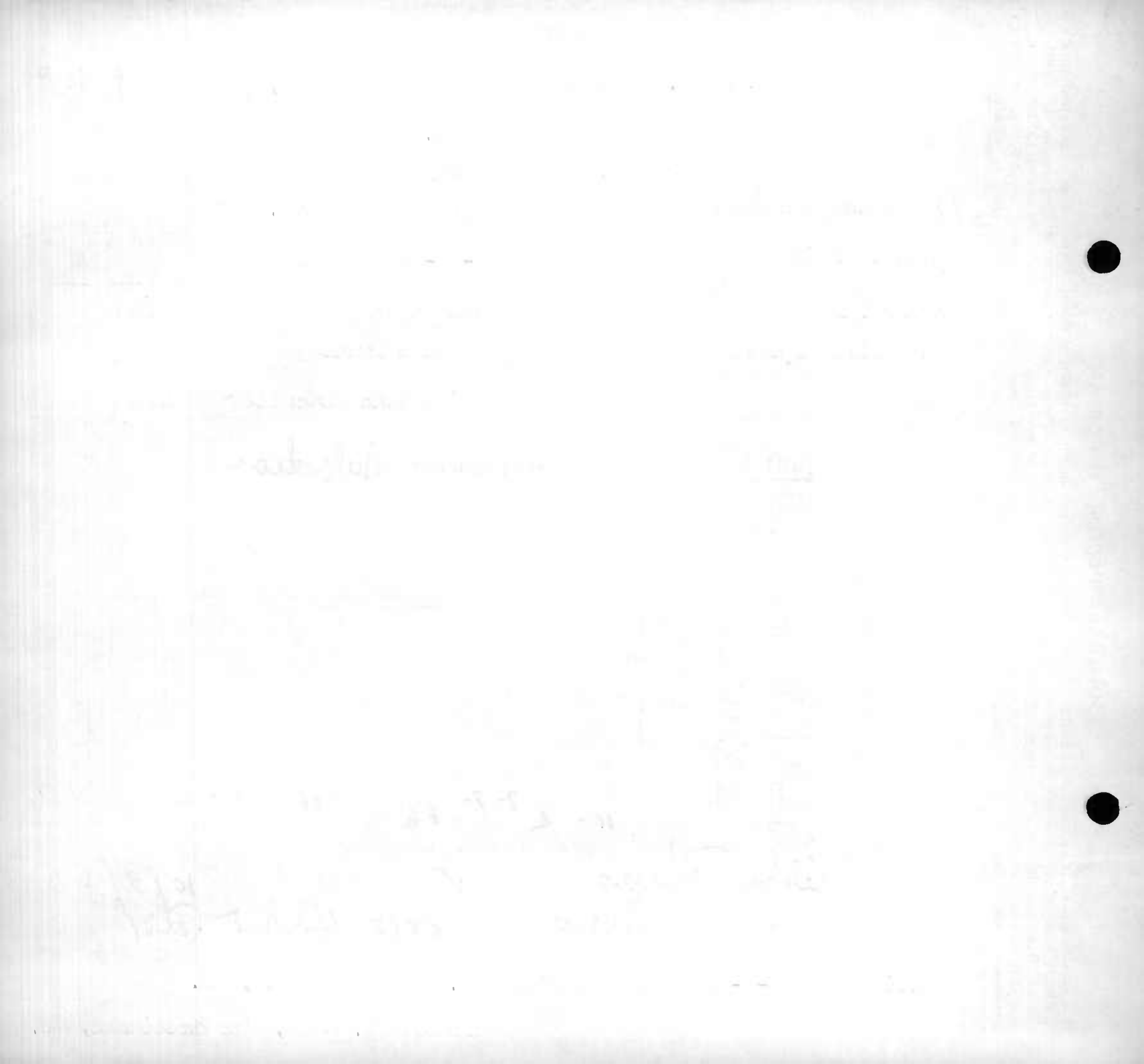
Very truly yours,  
[Signature]

Enclosed are also 100 copies of the  
report on the work done during the  
past year.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 09917	
CERTIFICATE OF DEATH				Registered No.	
BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mary T. McKevitt		October 2, 1966 9:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Harford Gardens Nursing Home 904700 Harford Road			Md. 27-01		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			5011 Eugene Ave.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
female	white	widowed	9-26-1886	80	Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Patrick McEnroe			Delia Owens		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				Miss Anna McKevitt - same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
420.1 I			Myocardial Infarction		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO		
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-7-1966 to 10-2-1966, that (I) (we) last saw the deceased alive on 10-2-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Sebastian Russo			10/3/66		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
SEBASTIAN RUSSO			5017 Harford Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
burial		10-6-66		Holy Redeemer Cem.	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 3 1966		Robert E. Taylor		Leonard J. Ruck, Inc Baltimore, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09918		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09918	
M.E. CASE NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		HELEN C. BURKE		SEPT. 29, 1966 10:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. DATE AND HOUR OF DEATH	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 21-01	
929 S. PACA ST. 00		C. CITY OR TOWN BALTIMORE		D. STREET ADDRESS (If rural, give township)	
929 S. PACA ST.		6. DATE OF BIRTH		7. AGE (In years last birthday)	
JAN - 14 1894		75		If Under 1 Yr. Months Days	
8. RACE WHITE		9. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		10. WIDOWED	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (State or foreign country)	
HOUSE-WIFE (Retired)		BALTIMORE, MD		14. CITIZEN OF WHAT COUNTRY? U-S-A	
15. FATHER'S NAME William A. Pick		16. MOTHER'S MAIDEN NAME Anna E. Hall		17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
18. SOCIAL SECURITY NO. 214-01-7664		19. INFORMANT HELEN WATSH-SOOTOCKSEV RD		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Carcinoma lunum metastatic (B) Carcinoma nigel (C) Breast		2 year 6 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/8 1954 to 8/22 1966. that (I) last saw the deceased alive on 8/22 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.					
23A. SIGNATURE John P. Urlock Jr.		M.D. Attending <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff <input type="checkbox"/>		23B. DATE SIGNED 9/30/66	
23C. PHYSICIAN'S NAME (Type) JOHN P. URLOCK JR.		23D. ADDRESS 1227 Washington Blvd			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE OCT 3 1966		24C. NAME OF CEMETERY or CREMATORY WESTERN CEMETERY	
24D. LOCATION (City, town, or county)		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 3 1966		25B. NAME OF REGISTRAR R. B. E. Johnson		25C. FUNERAL DIRECTOR F. B. WIPPERT	
25D. ADDRESS 1300 EUTAW PLACE					

10 23 3

1921

*Cucumis melo*  
*Cucumis melo*  
*Cucumis melo*  
*Cucumis melo*

1/2 1/2 1/2 1/2

1/2 1/2

1/2 1/2

1/2 1/2 1/2 1/2 1/2 1/2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 09919		CERTIFICATE OF DEATH		66 09919	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Wille, Josephine</i>		2. DATE AND HOUR OF DEATH <i>10/2/66 5:04 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b> <i>33</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> <i>3-01</i>			
		D. STREET ADDRESS (If rural, give location) <b>283 HERRING COURT</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGROID</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SEPARATED</b>	8. DATE OF BIRTH <b>11-24-95</b>	9. AGE (In years lost birthday) <b>70</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <b>CHARLES WASHINGTON</b>		14. MOTHER'S MAIDEN NAME <b>SINAH BRUCE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-12-85004</i>		17. INFORMANT <i>Alice Hoppe</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>199.2 I</b>		CAUSE OF DEATH (A) DUE TO <i>Metastatic carcinoma of the breast, involving the lung and brain</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pneumothorax</i>		<i>1 day</i>	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10/2/66</i> 19 <i>66</i> to <i>10/2</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>10/2</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David S. Fedson</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/2/66</i>	
23C. PHYSICIAN'S NAME (Type) <b>DAVID S. FEDSON</b>		23D. ADDRESS <i>The Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-2-1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT. Auburn Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1966</b>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>Chroy O. Wilson</i>	
				ADDRESS <i>1000 Brawley Ave.</i>	



Table 1. The results of the analysis of variance for the effect of the treatment on the growth of the fish.

Table 2.

Table 3.

A. 653

66 09920

BALTIMORE CITY HEALTH DEPARTMENT

66 09920

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Jack Arnett

2. DATE AND HOUR PRONOUNCED DEAD

October 1st 66 4:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 15-09  
4010 Clifton Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

11-26-1897

9. AGE (In years  
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Alabama

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Arnett

14. MOTHER'S MAIDEN NAME

Molley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Sabine Arnett

ADDRESS

Same

18.

422.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic Cardio-  
Vascular Disease

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Oct 1st 66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-6-66

23C. NAME OF CEMETERY or CREMATORY

Crown Cent

23D. LOCATION

(City, town, or county)

(State)

Lima, Md

24A. DATE REC'D BY HEALTH DEPT.

OCT 3 1966

24B. NAME OF REGISTRAR

Robert E. Feltz

24C. FUNERAL DIRECTOR

Choy Wilson

ADDRESS

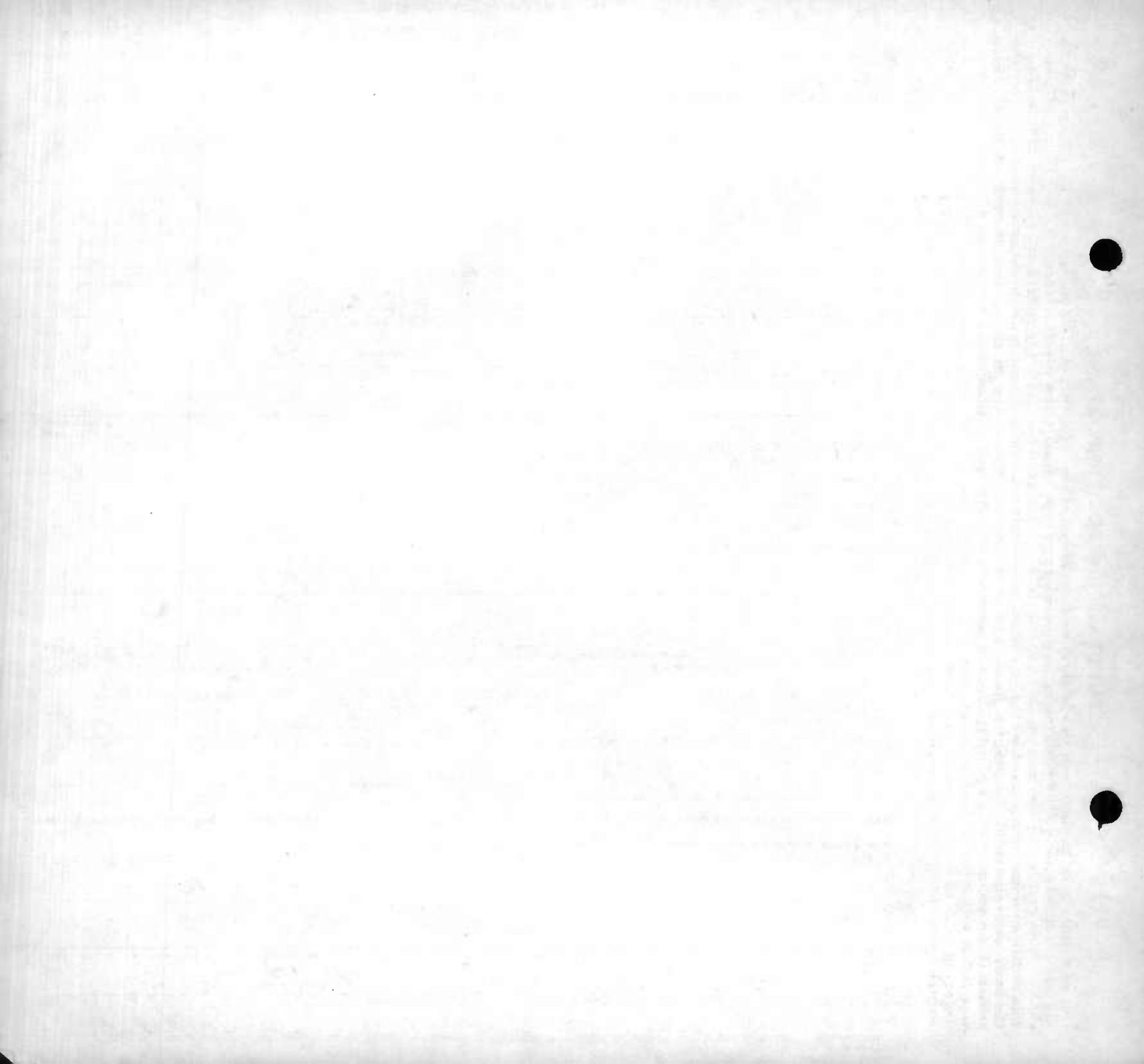
1000 Beantley

WALLER HONGKONG

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09921				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09921	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GRAVESANDE, WALTER H				2. DATE AND HOUR OF DEATH 9-30-66 4:20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL.				A. STATE B. COUNTY BAL MARYLAND. 15-10			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO				D. STREET ADDRESS (If rural, give location) <del>WILSON</del> 4010 Cold Spring Lane			
5. SEX M	6. RACE INDIAN-INDIA	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 9-21-07	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTAL TECHNICIAN		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) BRITISH GUIANA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME DONALD GRAVESANDE				14. MOTHER'S MAIDEN NAME GERTRUDE MC. LEAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. -		17. INFORMANT		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 58111 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH (A) UPPER GI. BLEEDING FROM ESOPHAGEAL VARICES DUE TO		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) CIRRHOSIS WITH HEPATIC COMA DUE TO		YEARS - 2 wks	
(C) CHRONIC & ACUTE ALCOHOLISM DUE TO				YEARS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 9-18 1966 to 9-30 1966, that (1) (we) lost saw the deceased alive on 9-30 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jay Martin Barnash				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-1-66	
23C. PHYSICIAN'S NAME (Type) M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-5-66		24C. NAME OF CEMETERY or CREMATORY Baltimore Nat Cent		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. OCT 3 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR E O Wilson		ADDRESS Baltimore	



ON APPROVAL BY  
FUNDAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner's office if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09922		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09922	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Pearl Hicks			2. DATE AND HOUR OF DEATH 10-1-66 10/1/66 8:00 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33 BALTIMORE, MD 21205			A. STATE MARYLAND B. COUNTY 8-03		
5. SEX F			6. RACE N		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE			8. DATE OF BIRTH 11/20/13		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME SOL HICKS			14. MOTHER'S MAIDEN NAME CLARA HICKS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Robert Hicks			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 035,41 10/1/66 Gram negative sepsis			INTERVAL BETWEEN ONSET AND DEATH ?		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 9/29 1966 to 10/1/1966, that (we) last saw the deceased alive on 10/1/1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Murray A. Katz			23B. DATE SIGNED 10/1/66		
23C. PHYSICIAN'S NAME (M.D.) MURRAY A. KATZ			23D. ADDRESS JOHNS HOPKINS HOSPITAL		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial Oct 5/66		24B. DATE Oct 5/66		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem	
24D. LOCATION (City, town, or county) (State) A.A. County Md		25A. DATE REC'D BY HEALTH DEPT. OCT 3 1966		25B. NAME OF REGISTRAR Robert E. Fadden	
25C. FUNERAL DIRECTOR Frank T. Ellickson		25D. ADDRESS 1129 N. Charles			

11/22/72  
11/22/72

Robert H. H.



BIRTH NO.

66 09923

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHNNY

LACEY

2. DATE AND HOUR PRONOUNCED DEAD

September 30, 1966

6:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

35 Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1400 E. Baltimore Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

11/3/1920

9. AGE (In years  
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life. Even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes World War II

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

John Lacey Jr.

66 09923

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Bronchopneumonia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Spinal Cord Compression  
DUE TO

(C) Subluxation of Cervical Vertebrae.

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

House

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

32 N. Caroline Street

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

9 17 '66 A

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Fell from 1st floor porch roof.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
9/30/6623A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Oct 5/66

23C. NAME of CEMETERY or CREMATORY

Bald Natl Cem

23D. LOCATION (City, town, or county) (State)

5501 Frederick Ave, Baltimore

24A. DATE REC'D BY HEALTH DEPT.

OCT 3 1966

24B. NAME OF REGISTRAR

Robert E. Lacey Jr.

24C. FUNERAL DIRECTOR

Milton E. Elchman 1129 N. Caroline St

ADDRESS

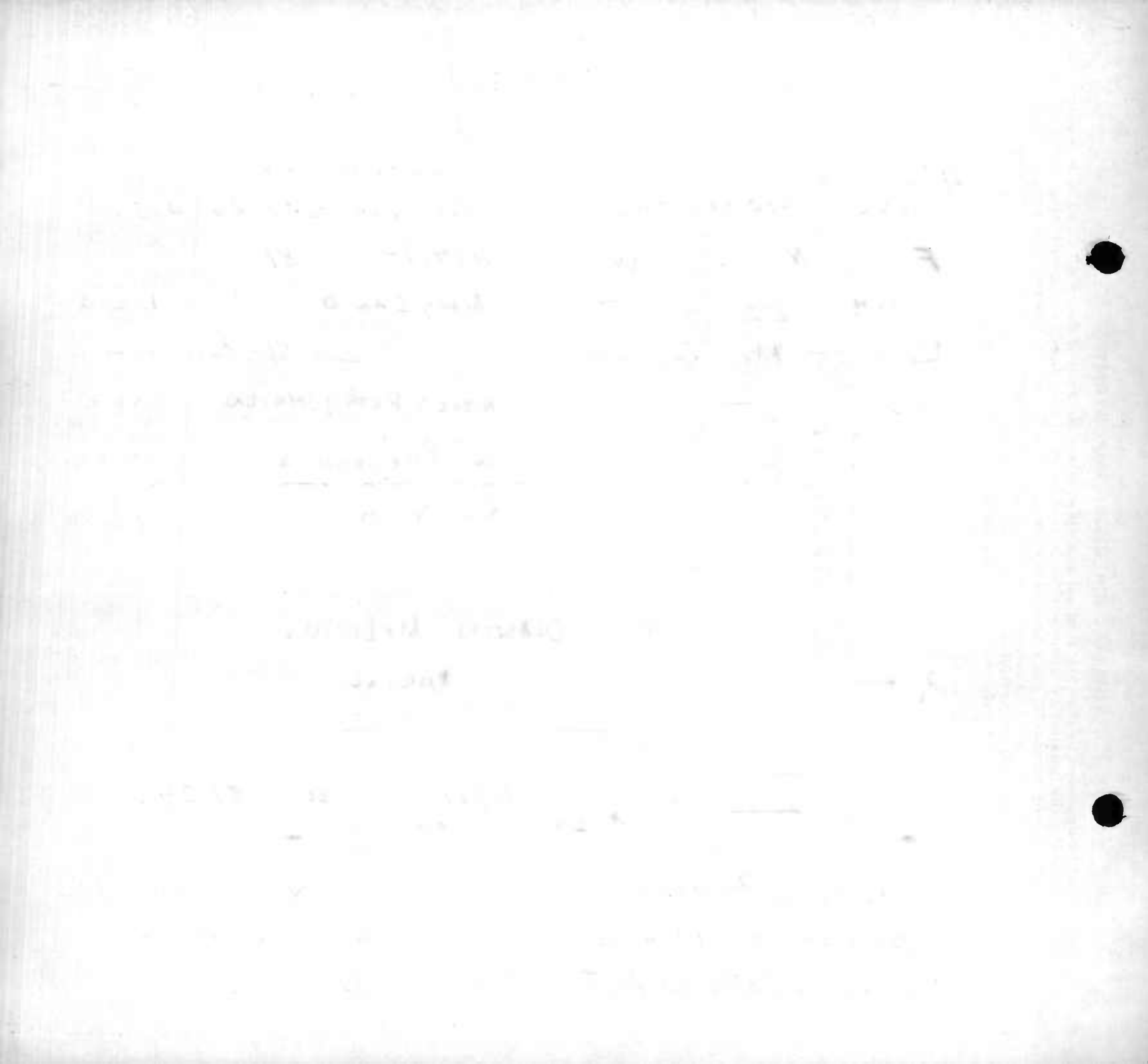




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09924		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09924	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ISABELL GREEN (NC21)		2. DATE AND HOUR OF DEATH 9/29/66 5:05 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD B. COUNTY 15-11			
FULL NAME OF HOSPITAL OR INSTITUTION 422 SINAI HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 3505 GRANTLEY RD #15			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 11/4/84	9. AGE (In years last birthday) 81	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WH		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Robert Mc GOWANS		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT NIECE: RUTH JOHNSON	
18. 331X + 1260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) BRONCHO PNEUMONIA DUE TO (B) C.V.A. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 18 DAYS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes Mellitus			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) Partial	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 9/11/66 to 9/29/66, that (I) (we) last saw the deceased alive on 9/29/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eduardo Hidalgo		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/29/66	
23C. PHYSICIAN'S NAME (Type) EDUARDO HIDALGO		M.D.		23D. ADDRESS SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/3/66		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Ch. Baltimore	
24D. LOCATION (City, town, or county) Md.		24E. DATE REC'D BY HEALTH DEPT. OCT 3 1966		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. FUNERAL DIRECTOR Adlington S. Phillips		24H. ADDRESS 1727 N. Mount St.			



R.200

66 09925

BALTIMORE CITY HEALTH DEPARTMENT

66 09925

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

John R. Rice

2. DATE AND HOUR PRONOUNCED DEAD

9/26/66

11:43 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

36

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1004 N. Carrollton Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

2/7/76?

9. AGE (In years  
last birthday)

90

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Robert Rice

14. MOTHER'S MAIDEN NAME

Miriam Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Ursula James 744 Daffin St

18.

177X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Carcinoma of prostate gland

(A).....  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B).....  
DUE TO

(C).....

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/27/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

90/1/66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

Baltimore

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 3 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

William S. Phillips 1727 N. Meade St

ADDRESS



5/7/03

Wendell

Miss Williams

Robert Rice

Thank you very much



Miss Williams

Thank you very much

F-626

66 09926

BALTIMORE CITY HEALTH DEPARTMENT

66 09926

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH M. PARKER Jr.

2. DATE AND HOUR PRONOUNCED DEAD

September 29, 1966 7:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

24 Jones Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4/2/1923

9. AGE (In years  
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Joseph M. Parker Sr.

14. MOTHER'S MAIDEN NAME

Elsie Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. If yes, give war or dates of service)

Yes

WW II

16. SOCIAL  
SECURITY NO.

234-22-6591

17. INFORMANT

Marjorie Parker

ADDRESS

Same

18. 303.2

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Status Epilepticus.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/29/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/4/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery

23D. LOCATION (City, town, or county) (State)

Baltimore MD

24A. DATE REC'D BY HEALTH DEPT.

OCT 3 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Arlington S. Phillips 1727 N. Mount St.

ADDRESS

WALLEY FUDGE

11/1/1903

Good morning

My dear Mr. Fudge

I have just received your letter of the 29th

and am glad to hear from you

I am well and hope this finds you the same

I am very truly yours

W. Fudge

P.S. I have just received your letter of the 29th

and am glad to hear from you

I am well and hope this finds you the same

I am very truly yours

W. Fudge

P.S. I have just received your letter of the 29th

and am glad to hear from you



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09927 66-20539		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09927	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Girl Bradford.		2. DATE AND HOUR OF DEATH 10-1-66 6 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION Church Home + Hospital 35 (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore MD B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 515 Arsen Ave 2225			
5. SEX Fem.	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Sep-29-1966	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert Bradford.		14. MOTHER'S MAIDEN NAME Linda Toler.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Robert Bradford. ADDRESS Same	
18. 762.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Due to (B) Due to (C) Due to		INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sep 29 - 19 66 to Oct. 1 19 66, that (I) (we) last saw the deceased alive on Oct 1st 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. A.E. Subong, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-2-66	
23C. PHYSICIAN'S NAME (Type) Dr. A.E. Subong, Jr.		23D. ADDRESS Church Home + Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/4/66		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem	
24D. LOCATION (City, town, or county) Glen Burnie Md		24E. AA Co		25A. DATE REC'D BY HEALTH DEPT. OCT 4 1966	
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR McCully FH		25D. ADDRESS 237 Patapsco Ave 21225	



Robert Bradford

201-66

Ch. H. House & Hospital

From White Sep-27-1914

Robert Bradford

Kinda Toler  
Robert Bradford

Robert Bradford

Oct 10 Sep 27-14

Ch. H. House & Hospital  
Sep-27-14

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 09928		CERTIFICATE OF DEATH		66 09928	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		KAISERSKI, NETTIE B.		9-29-66 12:10A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY			
(If not in hospital or institution, give street address or location)		MARYLAND			
40 ST. AGNES HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE ZONE 29			
		D. STREET ADDRESS (If rural, give location)			
		4123 POTTER STREET			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE	WIDOWED	7-31-77	89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
House Wife			MARYLAND		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
THOMAS LONG			Sarah Burkholds		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			17. INFORMANT ADDRESS		
			ST. AGNES RECORDS -CATON & WILKENS AVES		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(CVA) Prob thrombosis			
ANTECEDENT CAUSES		A. Cerebral Vascular thrombosis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		B. Arteriosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Left hip Inter-thoracic fracture			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
9-20-66	Fractured hip	NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
	Home	4123 Potter St. Baltimore			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
9 16 1966	While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	PAT. Fell on floor			
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 17 19 66 to SEPTEMBER 29 19 66, that (I) (we) last saw the deceased alive on SEPTEMBER 29 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Hugh Boyd Watts				9-29-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	Oct. 1, 1966	New Cathedral Cem.	Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
OCT 4 1966	Robert E. Farber	G. Truman Schwab		3512 Frederick Ave. Balto. Md.	

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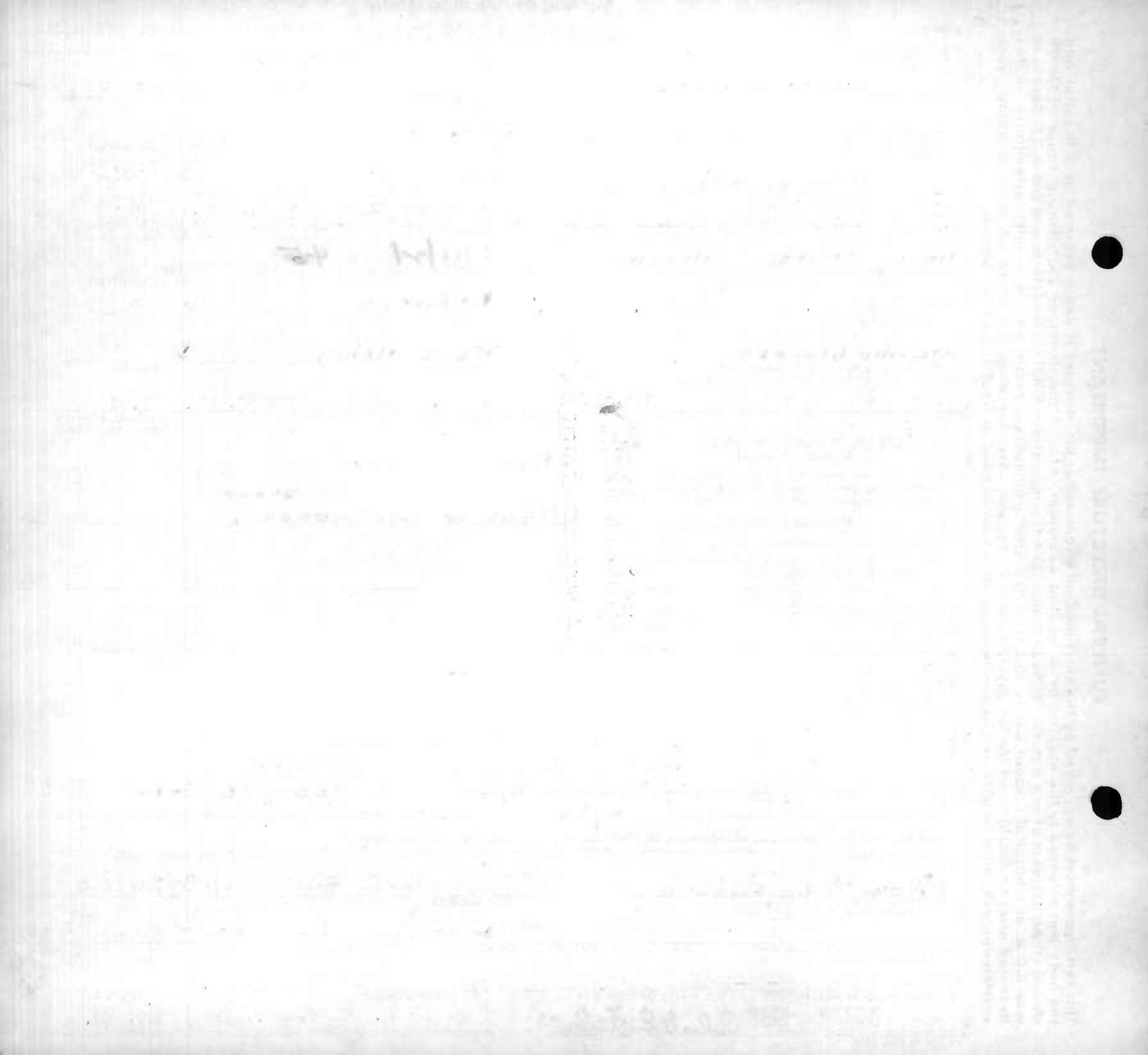
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09929				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09929	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>William Walker</u>				9/26/66 10:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
38 UNIVERSITY HOSPITAL				MARYLAND		ALLEGHENY	
				C. CITY OR TOWN		(If outside city limits, write RURAL and give township)	
				FROSTBURG		57-00	
				D. STREET ADDRESS (If rural, give location)			
				Box 35, Route 1 - WRIGHTS CROSSING			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
MALE	WHITE	MARRIED	6/12/21	45			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SHIPPING DEPT.		KELLY S. TIRE CO.		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM WALKER				EDITH ADAMS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
YES		WW 2 215-24-6765		EMMA C. WALKER, FROSTBURG, MD.		RT. 1	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.)				WATERBURY			
ANTECEDENT CAUSES				WATERBURY			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				WATERBURY			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 9/14 1966 to 26 Sept 1966, that (I) (we) last saw the deceased alive on 9/26 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Donald M. Barrick				9/26/66			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
DONALD M. BARRICK		UNIVERSITY HOSPITAL - BALTO, MD.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		9-30-1966		F.B.G. MEMORIAL PARK		FROSTBURG, MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 4 1966		Robert E. Faldut		JOSEPH R. DURST, SR.,		FROSTBURG, MD.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09930		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09930	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) OSTROVENUK OSTROVCHUK MR JOHN		2. DATE AND HOUR OF DEATH 9/30/66 2-55 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital 100 N. Broadway Baltimore, Md		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 1-02			
D. STREET ADDRESS (If rural, give location) 101 S. LINWOOD AVE. (24)					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH FEB 23 1897	9. AGE (In years, last birthday) 69 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY STANDARD OIL CO	11. BIRTHPLACE (State or foreign country) Russia	12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR I		16. SOCIAL SECURITY NO. 096-143201		17. INFORMANT ADDRESS A HARRY BUNDER 101 S LINWOOD AVE	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 9/22/66 to 9/30/66	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-22 1966 to 9-30 1966 that (I) (we) last saw the deceased alive on 9-30 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. A.E. Subong, SR M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9-30-66	
23C. PHYSICIAN'S NAME (Type) Dr. A.E. Subong, SR M.D.		23D. ADDRESS Church Home & Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE OCT 1 1966	24C. NAME OF CEMETERY OR CREMATORY HOLY TRINITY CEMETERY		24D. LOCATION (City, town, or county) (State) LAWYER HILL RD MD	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1966		25B. NAME OF REGISTRAR Robert E. Farkema		25C. FUNERAL DIRECTOR ADDRESS DIAPEL BROS INC 1800 E LOMBARD ST	

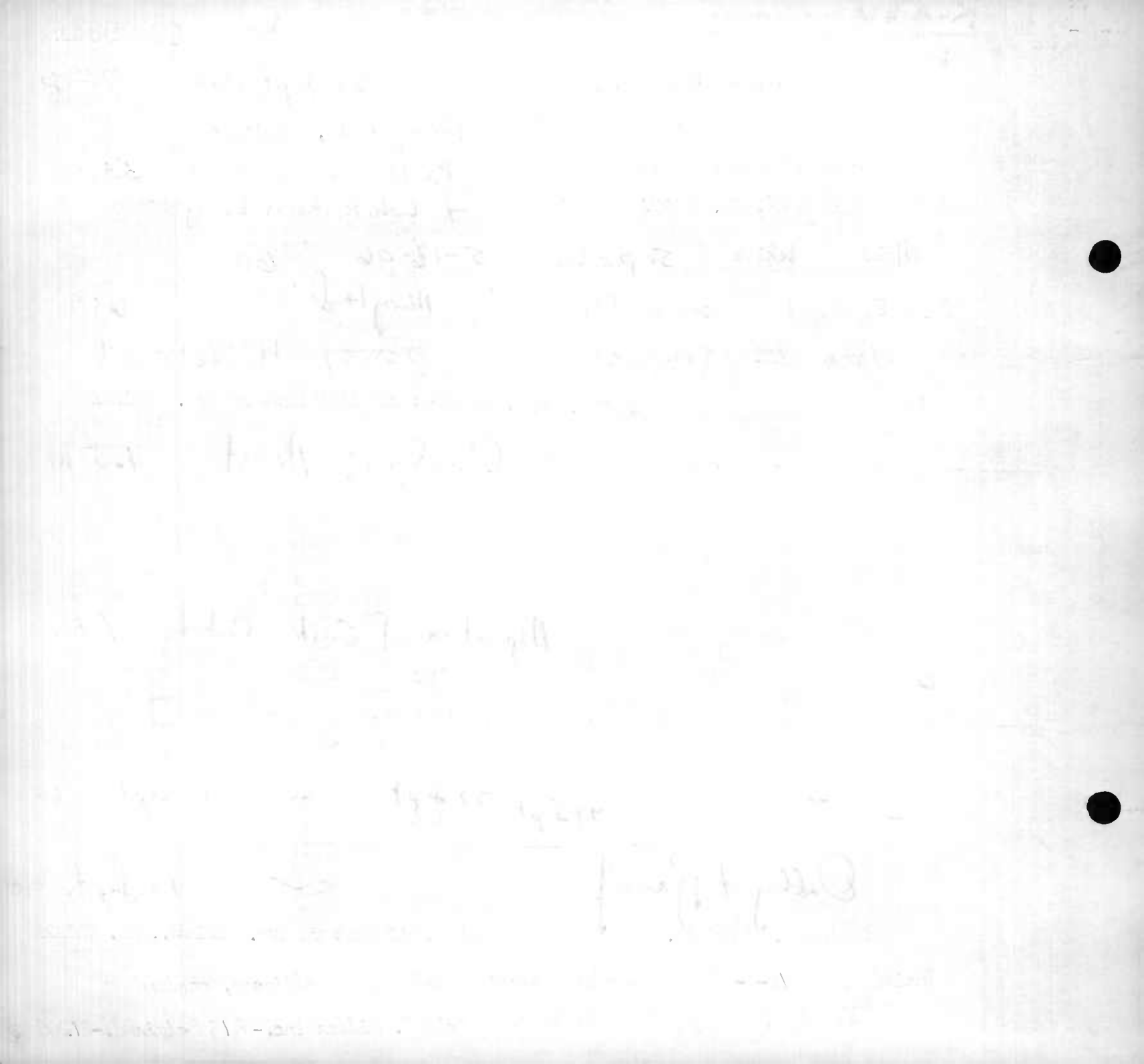


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09931		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09931	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John W Kammer		2. DATE AND HOUR OF DEATH 29 Sept 1966 7:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. #21224		Maryland, Baltimore Balto. County		Baltimore 53-00 4 White Thorn Way #21220	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 5-16-06	9. AGE (In years last birthday) 60	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Brooms, Mops,	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John I Kammer		14. MOTHER'S MAIDEN NAME Jenny Hildebrand		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 217-12-8294		17. INFORMANT RECORDS: BCH 4940 Eastern Ave. #21224		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) Cordiac Arrest		1.5 hr.	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Aspiration of Gastric Contents		1 hr.	
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
(APPROX.)	White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>				
22. I certify that (H) (this hospital) attended the deceased from 29 Sept 1966 to 29 Sept 1966, that (H) (we) last saw the deceased alive on 29 Sept 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dudley A Raine Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 29 Sept, 1966	
23C. PHYSICIAN'S NAME (Type) DUDLEY A. RAINE JR.		23D. ADDRESS M.D. BCH 4940 Eastern Ave. Balto., Md. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10-3-66	24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1966	25B. NAME OF REGISTRAR Robert E. Farley, MA	25C. FUNERAL DIRECTOR ADDRESS John C. Miller Inc. - 415 Belair Rd. - 21206			





C-613

66 09932

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09932

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EARL Dayton CRABTREE

2. DATE AND HOUR PRONOUNCED DEAD

September 30, 1966 8:08 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

501 N. Wolfe Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb. 18, 1905

9. AGE (In years  
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Steel Mill.

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph E. Crabtree

14. MOTHER'S MAIDEN NAME

Annie Hines

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

218-07-4621

17. INFORMANT

ADDRESS

Minnie L. Crabtree-Baltimore, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/30/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/3/66

23C. NAME of CEMETERY or CREMATORY

Philos

23D. LOCATION (City, town, or county) (State)

Westernport

Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 4 1966

24B. NAME OF REGISTRAR

Robert E. Fadden

24C. FUNERAL DIRECTOR

E. L. Boyd

ADDRESS

Westernport, Md.

VALLEY POLICE

Investigator

Officer

Chief

2017

1000

100

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 47878-34 4	
BIRTH NO. 662005266 09933				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>HENSON baby boy Noreen</i>				2. DATE AND HOUR OF DEATH <i>9-25-66 11:30 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31 BALTIMORE City Hospital 4940 Eastern Ave. Baltimore, Maryland # 21224 007</i>				A. STATE <i>BALTIMORE</i> X8. COUNTY <i>Maryland Balto.</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 53-00</i>			
				D. STREET ADDRESS (If rural, give location) <i>317B MALVIN Ave -</i>			
5. SEX <i>MALE</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never Married</i>	8. DATE OF BIRTH <i>9-25-66</i>	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE (Md)</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Revern Henson</i>			14. MOTHER'S MAIDEN NAME <i>HENSON Noreen</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>BCH: Records</i> ADDRESS <i>Mother 4940 Eastern Ave. Baltimore Md. 21224</i>		
18. <i>760.51</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>cerebral hemorrhage</i> DUE TO <i>and anoxia</i> (B) <i>Prematurity</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>11:30 h.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>9-25</i> 19 <i>66</i> to <i>9-25</i> 19 <i>66</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>9-25</i> 19 <i>66</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <i>L. Risenberg</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>9-25-66</i>			
23C. PHYSICIAN'S NAME (Type) <i>LUNA RISEMBERG</i>				23D. ADDRESS <i>Baltimore City Hospitals 6536 E. Pratt Street, Balt. Md 21224 4940 Eastern Ave. Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>9-26-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore City Hospitals</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland 21224</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 4 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Finkema</i>		25C. FUNERAL DIRECTOR		ADDRESS <i>MORTUARY SERVICE - BCHD</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09934</u>	
BIRTH NO. <u>66 09934</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>FRANCIS J. SCHMIDBAUER</b>		2. DATE AND HOUR OF DEATH <b>SEPT. 27, 1966</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b> <b>WILKENS AVENUE AND CATON AVENUE</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		D. STREET ADDRESS (If rural, give location) <b>1920 GRINNALDS AVENUE 21230</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4-26-1903</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. If Under 24 Hrs. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UPHOLSTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>LENHARDT SCHMIDBAUER</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-05-4430</b>		17. INFORMANT ADDRESS <b>MRS. EVELYN M. SCHMIDBAUER, 1920 GRINNALDS AVE.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b> <b>Coronary Occlusion</b> <b>Instant</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>Cardiovascular Disease</b> <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <u>Jan 19 1963</u> to <u>Sept 27 19 66</u> , that (I) (we) last saw the deceased alive on <u>Sept 15 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death.					
23A. SIGNATURE <i>Abram Goldman</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>9/28/66</u>	
23C. PHYSICIAN'S NAME (Type) <b>ABRAM GOLDMAN</b>		23D. ADDRESS <b>4123 FREDERICK AVENUE (ROAD)</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>OCT 4 1966</b>		24C. NAME of CEMETERY or CREMATORY <b>LOUDON PARK CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <u>Oct 4 1966</u>			
25B. NAME OF REGISTRAR <i>Robert E. Hubbard</i>		25C. FUNERAL DIRECTOR ADDRESS <b>HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229</b>			

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U. S. DEPARTMENT OF AGRICULTURE, BUREAU OF PLANT INDUSTRY, WASHINGTON, D. C.

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U. S. DEPARTMENT OF AGRICULTURE, BUREAU OF PLANT INDUSTRY, WASHINGTON, D. C.

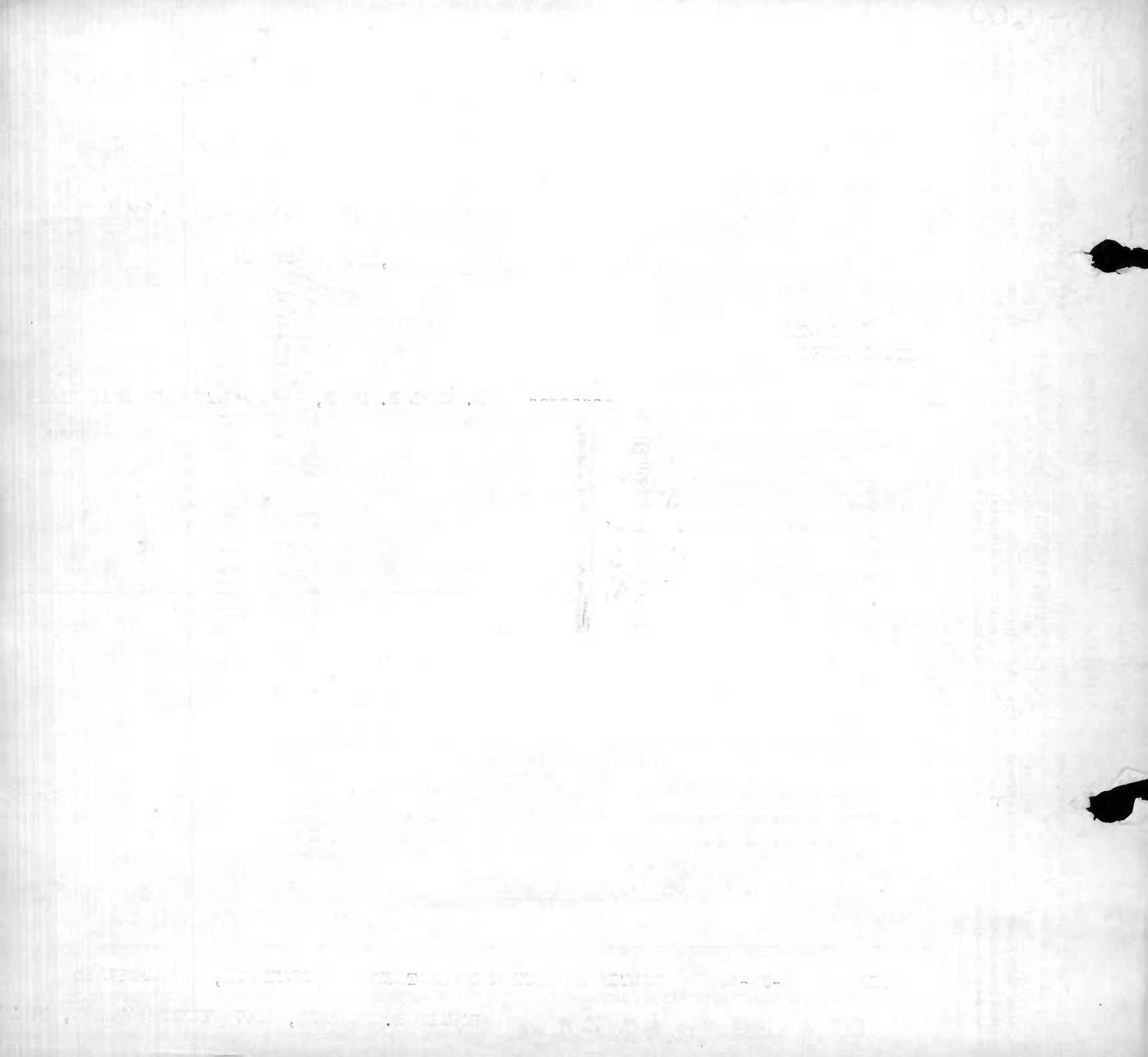
1912



Dr. Spitz, Medical Examiner called (1300H) Approved  
FUNERAL DIRECTOR: IMPORTANT  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09935	
BIRTH NO. 66 09935				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Mohr, Dorothy Rose</i>		2. DATE AND HOUR OF DEATH <i>27 Sept 1966 12:00 noon</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>Baltimore</i>	
<i>38 University of Md. Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>1104 Montgomery Road</i>	
5. SEX <i>Female</i>	6. RACE <i>Cau.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>13 Aug, 1911</i>	9. AGE (In years last birthday) <i>55</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>EDWIN</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ritz.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>M-----</i>		17. INFORMANT ADDRESS <i>MR. CARL R. MOHR, 1104 MONTGOMERY ROAD 21227</i>	
18. <i>451X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Aortic rupture</i> DUE TO (B) <i>Atherosclerosis</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Rheumatic Valvular disease, M.S., M.R.</i>			
19A. DATE OF OPERATION <i>27 Sept. 1966</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Mitral valvular prosthesis</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natally medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>21 Sept. 1966</i> to <i>27 Sept. 1966</i> , that (I) (we) last saw the deceased alive on <i>27 Sept. 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Santos, C.D.</i>				23B. DATE SIGNED <i>27 Sept. 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>Delvin S. Santos</i>				23D. ADDRESS <i>University of Md. Hosp.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9-30-66</i>		24C. NAME of CEMETERY or CREMATORY <i>BALTIMORE NATIONAL CEMETERY</i>	
24D. LOCATION (City, town, or county) <i>BALTIMORE,</i>		24E. STATE <i>MARYLAND</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 4 1966</i>		25B. NAME OF REGISTRAR <i>C. B. E. Feltner</i>		25C. FUNERAL DIRECTOR ADDRESS <i>HOWARD H. HUBBARD, 4107 WILKENS AVENUE, 21229</i>	

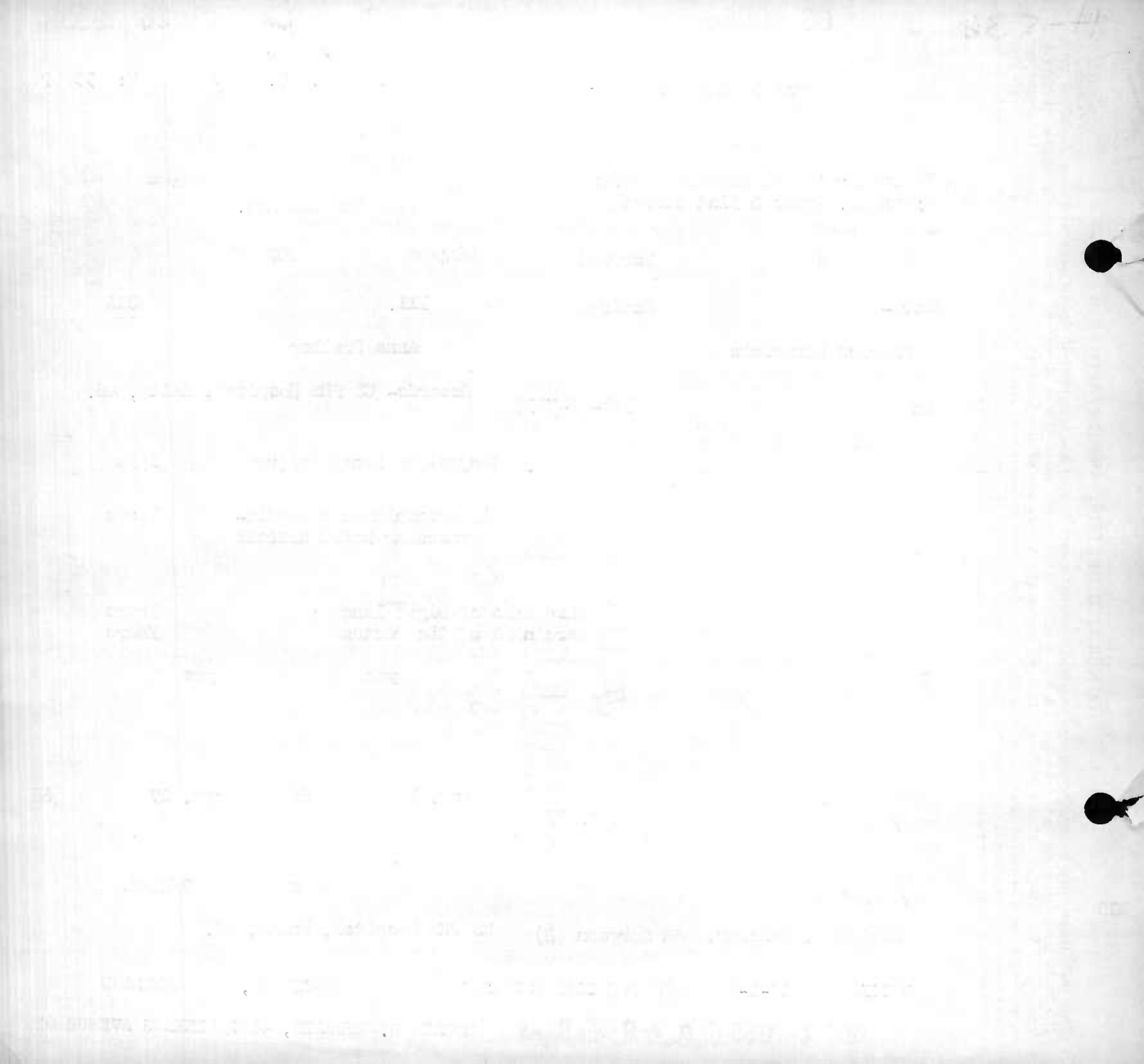




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

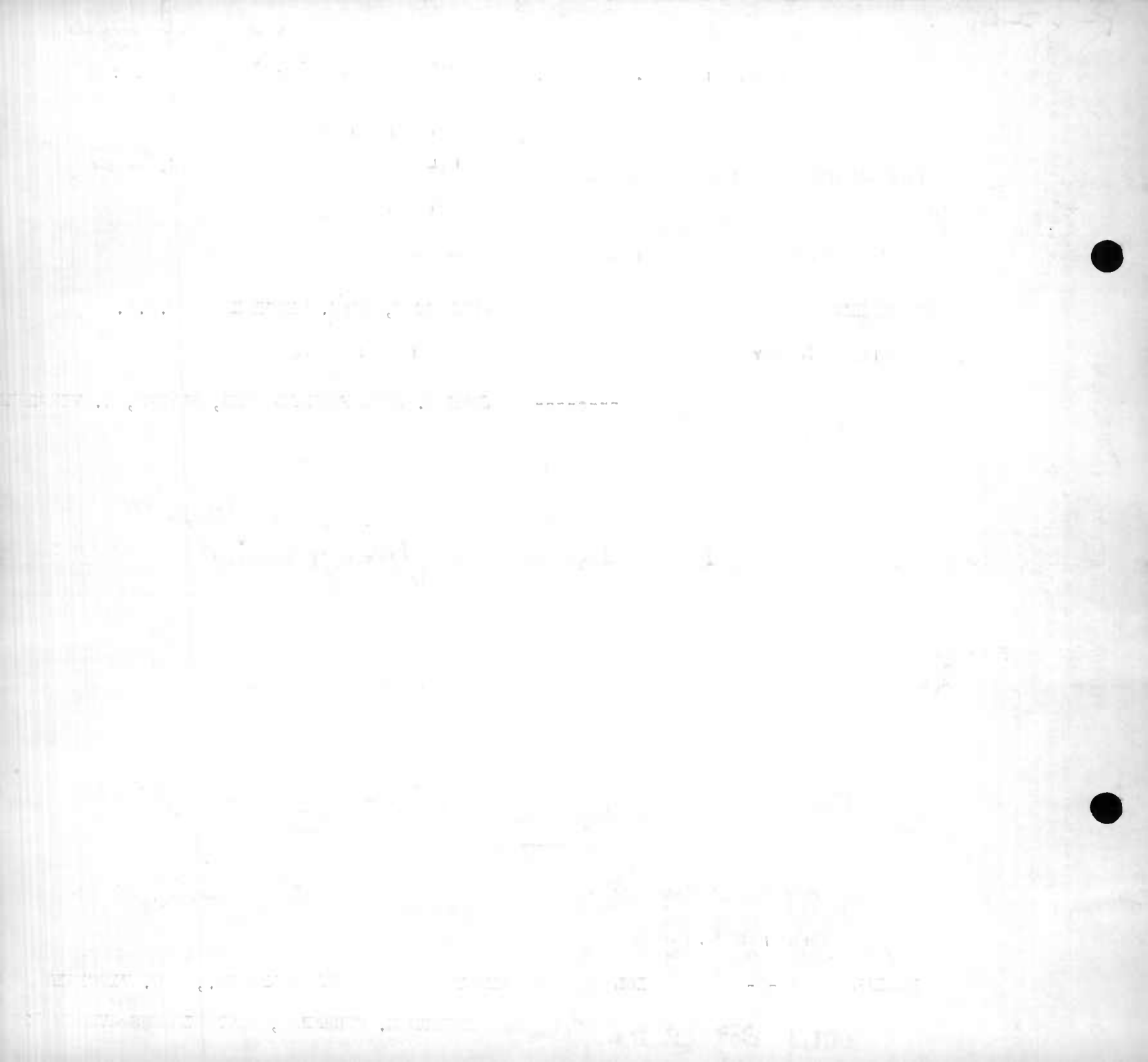
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 09936		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Kenneth Cuba Hendricks		Sept. 27, 1966		7: 35 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland			
US Public Health Service Hospital		B. COUNTY Montgomery County			
Wyman Pk. Drive & 31st Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Bethesda			
D. STREET ADDRESS (If rural, give location)		7929 Norfolk Ave.			
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 8/24/98		9. AGE (In years last birthday) 68		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Ill.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Hendricks			
14. MOTHER'S MAIDEN NAME Anna Prather		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 381-03-7839		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.114-179.2		CAUSE OF DEATH (A) DUE TO Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH Days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Arteriosclerotic cardiovascular heart disease		Years	
(C) _____		Years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Carcinoma of right lung Carcinoma of the rectum		Years Years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Aug. 1 19 66 to Sept. 27 19 66, that (2) (we) lost saw the deceased alive on Sept. 27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael E. Pelczar				23B. DATE SIGNED 9/28/66	
23C. PHYSICIAN'S NAME (Type) Michel E. Pelczar, SA Surgeon (R)				23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-1-66		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. OCT 4 1966			
25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

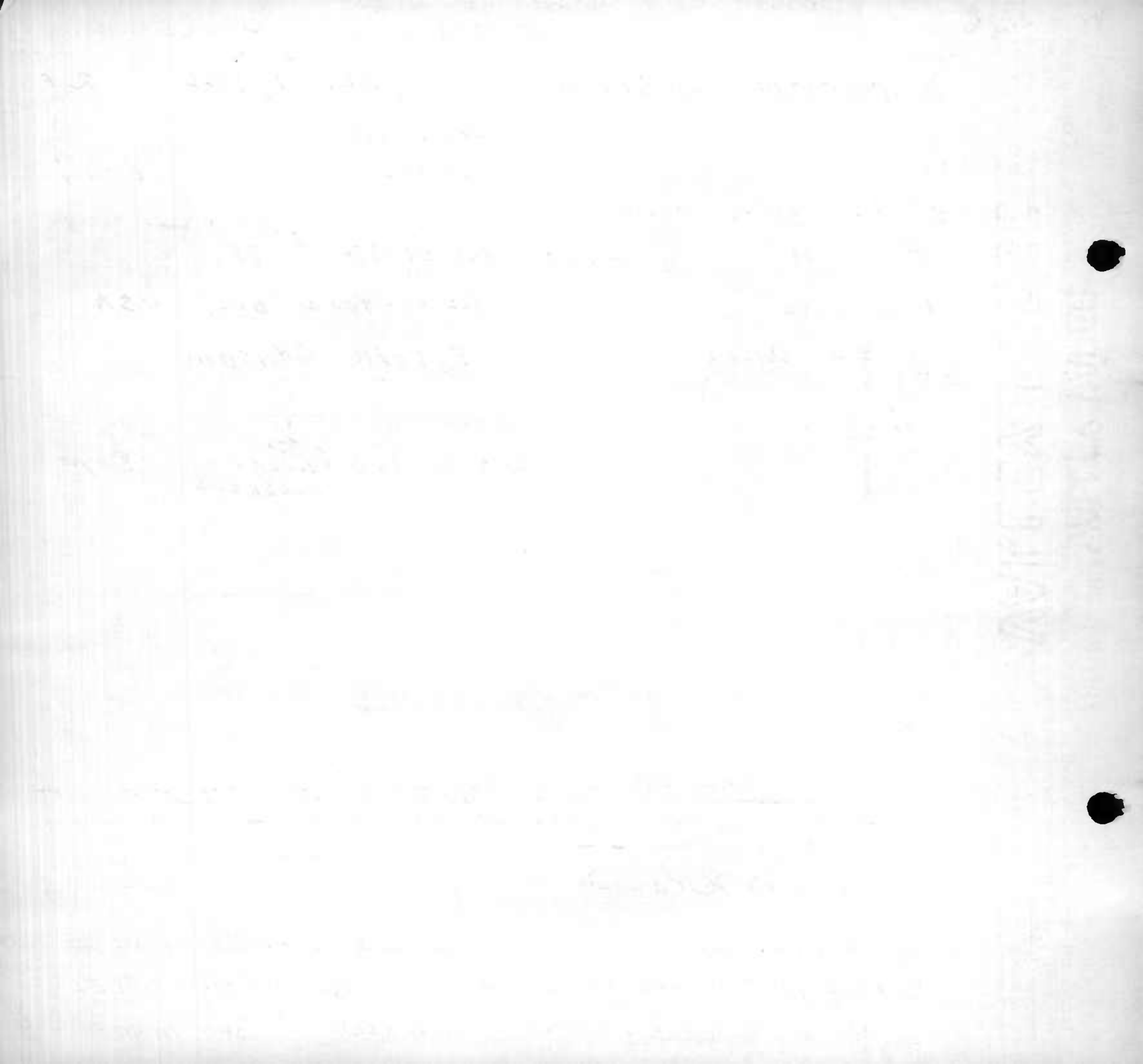
BIRTH NO. 66 09937		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09937	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOSEPHINE D. PARRACK		2. DATE AND HOUR OF DEATH 9-28-66 8:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY WEST VIRGINIA C. CITY OR TOWN (If outside city limits, write RURAL and give township) MILL CREEK V-45 D. STREET ADDRESS (If rural, give location) ROUTE 4			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-21-13	9. AGE (In years last birthday) 52	(If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BELINGTON, WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CECIL DELANEY		14. MOTHER'S MAIDEN NAME BESSIE SIMMONS		17. INFORMANT ADDRESS JOHN W. LOHR FUNERAL HOME, ELKINS, W. VIRGINIA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -----			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Respiratory Failure (A) DUE TO metastatic Carcinoma of the Breast (B) DUE TO Adeno Carcinoma of the left breast ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 6-20-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Metastatic Ca of Breast		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) no	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 18 Sept 66 19 to 28 Sept 66 19 that (I) (we) last saw the deceased alive on 28 Sept 66 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William B. Iams M.D.		23B. DATE SIGNED 28 Sept 66		23C. PHYSICIAN'S NAME (Type) WILLIAM B. IAMS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-3-66		24C. NAME OF CEMETERY or CREMATORY MILL CREEK CEMETERY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR OCT 4 1966 R. B. E. F. Adams		25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 09938					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 66 09938				
1. NAME OF DECEASED (Type or Print) <b>MAGGIE MUSTARD</b>					2. DATE AND HOUR OF DEATH <b>OCT 1 1966 2 P M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 GOULD CONY HOME</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>DELAWARE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>LEWIS</b> D. STREET ADDRESS (If rural, give location) <b>K-07</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>OCT 27, 1880</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GEORGETOWN DEL.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>J. ED. DAVIS</b>					14. MOTHER'S MAIDEN NAME <b>ESTHER CHASAM</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT ADDRESS				
18. <b>450.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>GENERACIZED ARTERIO SCLEROSIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) <b>GENERACIZED ARTERIO SCLEROSIS</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5ym</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>JUN 15 1966</b> to <b>OCT 1 1966</b> , that (I) (we) last saw the deceased alive on <b>SEPT 28 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Emmett P. Davis</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10-3-66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Emmett P. Davis</b>					23D. ADDRESS <b>5317 Belair Road - Baltimore, Maryland 21206</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/5/66</b>		24C. NAME of CEMETERY or CREMATORY <b>CONLEY CHAPEL</b>		24D. LOCATION (City, town, or county) (State) <b>GEORGETOWN DEL</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>CONNELLY</b>		ADDRESS <b>300 MACE</b>			



1  
C-450

66 09939

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09939

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ROLAND JERRY CULLUM

2. DATE AND HOUR PRONOUNCED DEAD

October 1, 1966 2:51 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

John Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

HARFORD

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

ABERDEEN, MD Harve de Grace

D. STREET ADDRESS (If rural, give location)

319 So. DEEN, ST.  
864 Erie Street Apt. 5

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

OCT 18, 1942

9. AGE (In years  
lost birthday)

24 23

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.

11 13

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

NURSING ASSISTANT

10B. KIND OF BUSINESS OR INDUSTRY

HARFORD MEMORIAL HOSPITAL

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ROLAND H. CULLUM

14. MOTHER'S MAIDEN NAME

KATHERINE GRIFFITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown); (If yes, give war or dates of service)

—

16. SOCIAL  
SECURITY NO.

26-38-4923

17. INFORMANT

ELIZABETH S. CULLUM

ADDRESS

319 So. DEEN ST  
ABERDEEN MD

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Cranio-cerebral Injury  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

284 ft. W. of Ebenezer Rd. at Rt. 40

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

10 1 '66 2:30A

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

(Dec. Driver) truck  
auto hit and went under a tractor trailer

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/1/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

OCT. 3, 1966

23C. NAME OF CEMETERY or CREMATORY

PRINCIPAL CEM.

23D. LOCATION

(City, town, or county)

CECIL CO.

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS



WILLIAM BOGGS

HARRIS  
HARRIS  
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 09940		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09940	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span><b>CERTIFICATE OF DEATH</b></span> <span></span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>M.E. CASE NO.</span> <span>1. NAME OF DECEASED (Type or Print) <b>LUDVIK, FRANCIS J.</b></span> <span>2. DATE AND HOUR OF DEATH <b>Oct 2, 1966 3 A M.</b></span> </div>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>44 Union Memorial Hosp.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 13-07</b> D. STREET ADDRESS (If rural, give location) <b>3820 ROLAND AVE</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>01-26-01</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CHIEF OF SURVEY BUREAU OF SEWERS</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BALTO CITY</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>JOSEPH LUDVIK</b>		
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>?</b>			17. INFORMANT <b>EVELYN D. LUDVIK - 3820 ROLAND AVE</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>331X I</b>			CAUSE OF DEATH (A) <b>CEREBRAL HAEMORRHAGE</b> DUE TO (B) _____ DUE TO (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 1 1966</b> to <b>Oct 2 1966</b> , that (I) (we) last saw the deceased alive on <b>Oct 1 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Zoltan Zarday</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Oct 2, 1966</b>
23C. PHYSICIAN'S NAME (Type) <b>ZOLTAN ZARDAY</b>			23D. ADDRESS <b>Union Memorial Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/5/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Old Frederick Rd, Md</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>OCT 4 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Faulkner</b>		25C. FUNERAL DIRECTOR <b>Quentin E. Donovan - 3818 Roland Ave</b>			

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# **FUNERAL DIRECTOR: IMPORTANT**

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BIRTH NO. 66 09941		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09941	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Maggie Alberta Bell</u>		2. DATE AND HOUR OF DEATH <u>9/30/66</u> <u>8:50 A.M.</u>			
3. PLACE OF DEATH <u>IN BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore County</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 53-00</u>			
		D. STREET ADDRESS (If rural, give location) <u>2317 Joppa Road</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 18, 1894</u>	9. AGE (In years last birthday) <u>71-72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Off Food-off</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Frances B. Spring, Lutherville, Md.</u>	
18. <u>E 903.0</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Embolus</u>		(A) <u>Fracture of Femur</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>None</u>		(B) <u>None</u>			
		(C) <u>None</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>None</u>					
19A. DATE OF OPERATION <u>8/4/66 + 8/22/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Torn Left Hip Requiring Chondroplasty</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>STREET</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>In front of 2317 E. Joppa Rd.</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>8/4/66 12:00 P.M.</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Tripped and fell.</u>	
22. I certify that (H) (this hospital) attended the deceased from <u>8/31/66</u> 19 <u>66</u> to <u>9/30</u> 19 <u>66</u> , that (H) (we) last saw the deceased alive on <u>9/30</u> 19 <u>66</u> and that (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>David S. Schwartz</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/30/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DAVID S. SCHWARTZ</u>		23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Oct. 3, 1966</u>	24C. NAME of CEMETERY or CREMATORY <u>Sater's Baptist Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Lutherville, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>	

Handwritten text, possibly a signature or name, located in the center of the page.

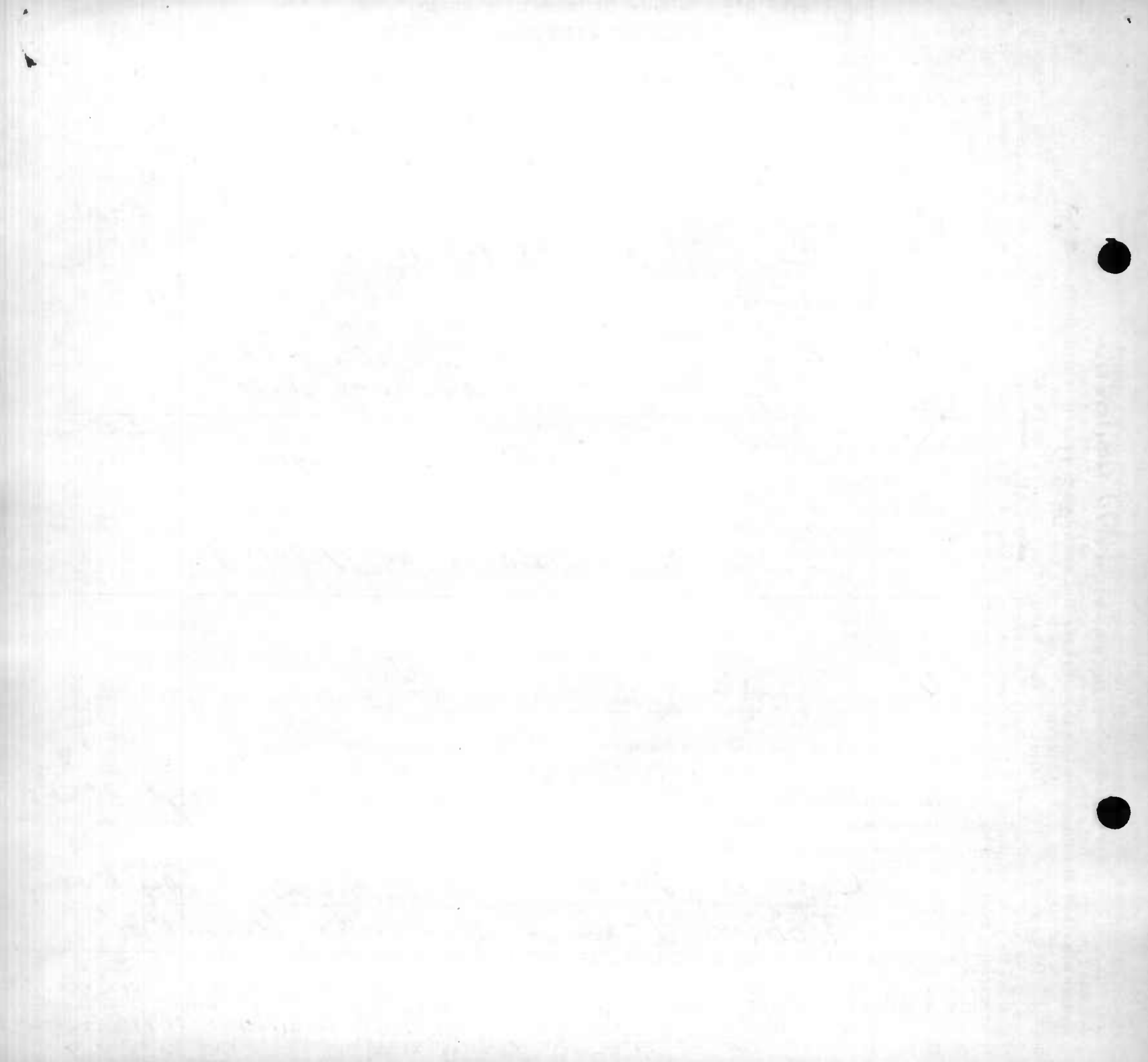
DATE 1920 JAN 8

5710112 2 01/20

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09942	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		ERNEST LEE		2. DATE AND HOUR OF DEATH Sept 29 - 66 10:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		A. STATE B. COUNTY Spring Grove State Hospital			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Balto. County			
38		D. STREET ADDRESS (If rural, give location) 53-00			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH Feb. 16-26	9. AGE (In years last birthday) 40	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturing worker		10B. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) Ind.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Wm. Ed. Lee		14. MOTHER'S MAIDEN NAME Marjorie Lee	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 21910-6050		17. INFORMANT admission sheet	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute anemia		CAUSE OF DEATH (A) DUE TO Duodenal ulcer.		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Basilar artery insuff.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 13 1966 to Sept 29 1966, that (I) (we) last saw the deceased alive on Sept 29 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodrigo Toro		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sept 29/66	
23C. PHYSICIAN'S NAME (Type) RODRIGO TORO		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/4/66		24C. NAME of CEMETERY or CREMATORY Longview	
24D. LOCATION Cockeysville, Balto. Co. Md.		(State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1966		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Wm. L. Chatman	
				ADDRESS 1701 Mrs. Cullen St Baltimore, Md	

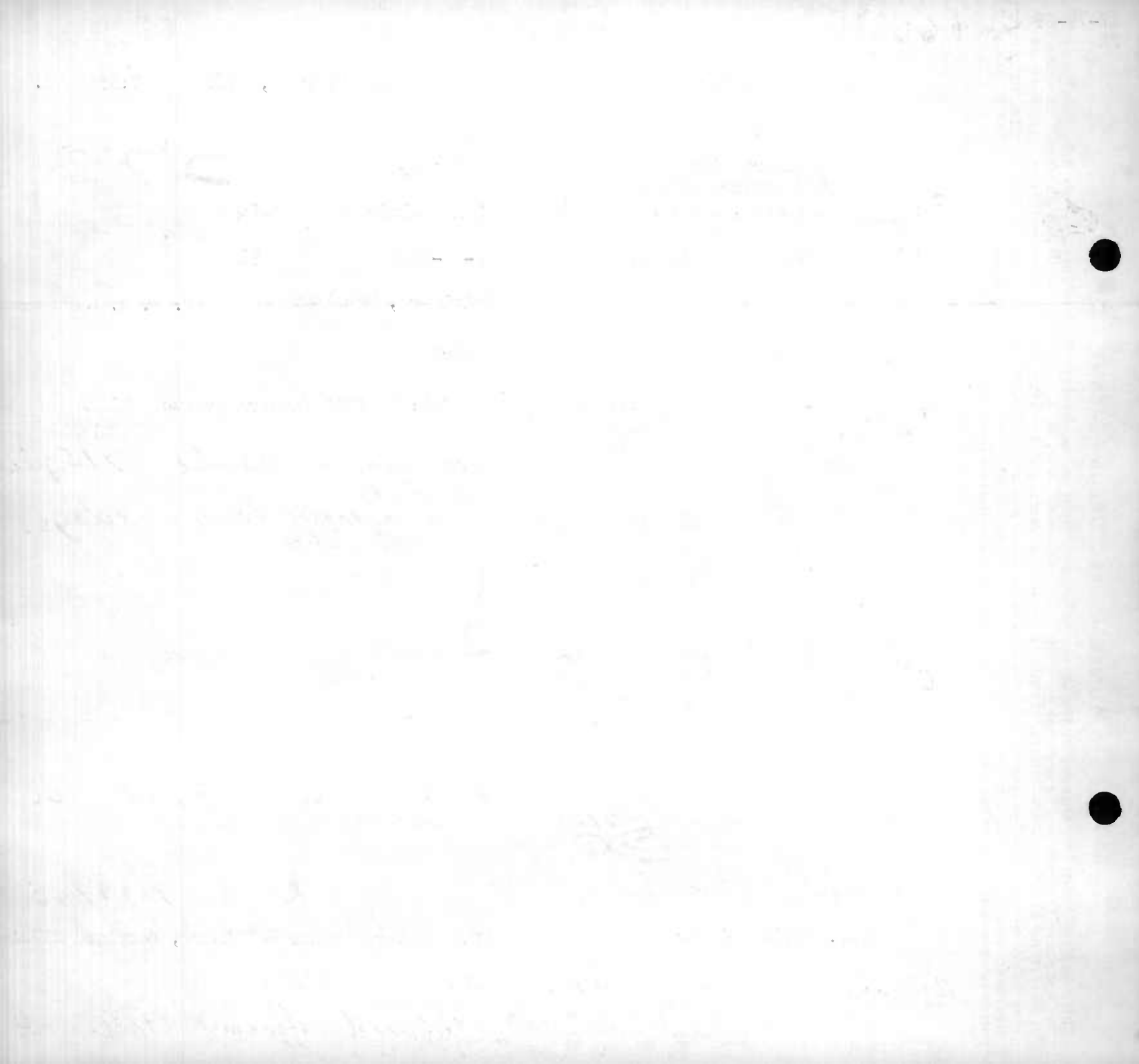




This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09943				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09943	
1. NAME OF DECEASED (Type or Print) <b>Bertha Koehler</b>				2. DATE AND HOUR OF DEATH <b>September 29, 1966</b>   <b>7:35</b> <b>P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b> <b>31</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>6116 Belair Road 21206</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>1-20-1875</b>	9. AGE (In years last birthday) <b>91</b>	If Under 1 Yr. Months Days Hours Min.	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		
13. FATHER'S NAME <b>Frederick August</b>			14. MOTHER'S MAIDEN NAME <b>Dohris</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>215-46-6655</b>		17. INFORMANT <b>REC ORDS: BCH 4940 Eastern Avenue 21224</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>450.1 I</b> <b>Arteriosclerotic vascular disease</b> <b>ischemic necrosis lower extremities</b>				INTERVAL BETWEEN ONSET AND DEATH <b>715 years</b> <b>3 days</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>9/27</b> 19 <b>66</b> to <b>9/29</b> 19 <b>66</b> , that (1) (we) last saw the deceased alive on <b>9/29</b> 19 <b>66</b> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>David Swimmer</b> M.D.				23B. DATE SIGNED <b>9/29/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. David Swimmer</b>				23D. ADDRESS M.D. <b>4940 Eastern Avenue Baltimore, Maryland 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-3-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Pk.</b>			
24D. LOCATION <b>md.</b>		24E. NAME OF REGISTRAR <b>Robert E. Taylor</b>		24F. FUNERAL DIRECTOR <b>Thelma M. Hoffmann</b>			
24G. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>		24H. NAME OF REGISTRAR <b>Robert E. Taylor</b>		24I. ADDRESS <b>3218 Loudon St</b>			





47-41-42  
JJ

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BALTIMORE CITY HEALTH DEPARTMENT	
47-41-42				47-41-42	
66 09944				66 09944	
BIRTH NO.				Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>EVANIK, JOHN</b>			2. DATE AND HOUR OF DEATH <b>10-1-66</b> <b>5:00 P. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>			A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give town, ship) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2015 Annapolis Rd. 21230</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never married</b>	8. DATE OF BIRTH <b>9-7-30</b>	9. AGE (In years last birthday) <b>35</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>			11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>Advertising</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>LEOPOLD</b>			14. MOTHER'S MAIDEN NAME <b>MARY ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>175-24-6601</b>		
17. INFORMANT <b>RECORDS: BCH 4940 EASTERN AVENUE #21224</b>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>002.1 + 1322.2</b>			CAUSE OF DEATH (A) DUE TO <b>Pulmonary tuberculosis</b> (B) DUE TO (C) DUE TO		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			21. <b>Alcoholism</b>		
22. I certify that (I) (this hospital) attended the deceased from <b>8-8-66</b> to <b>10-1-66</b> , that (I) (we) last saw the deceased alive on <b>10-1-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			23. DATE SIGNED <b>10-1-66</b>		
24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			25. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>		
26. DATE <b>10-4-66</b>			27. NAME OF CEMETERY or CREMATORY <b>St John the Baptist</b>		
28. NAME OF CEMETERY or CREMATORY <b>St John the Baptist</b>			29. LOCATION (City, town, or county) (State) <b>Doylstown Pa.</b>		
30. NAME OF REGISTRAR <b>Robert E. Farkner</b>			31. FUNERAL DIRECTOR <b>Walter Dabrowski 1005 Dundalk Ave.</b>		
32. NAME OF REGISTRAR <b>Robert E. Farkner</b>			33. FUNERAL DIRECTOR <b>Walter Dabrowski 1005 Dundalk Ave.</b>		

ENTHUSIASTIC

10-1-66

MD

BALTIMORE

BALTIMORE CITY HOSPITAL

5015 Avenue B

32

4-5-30

never married

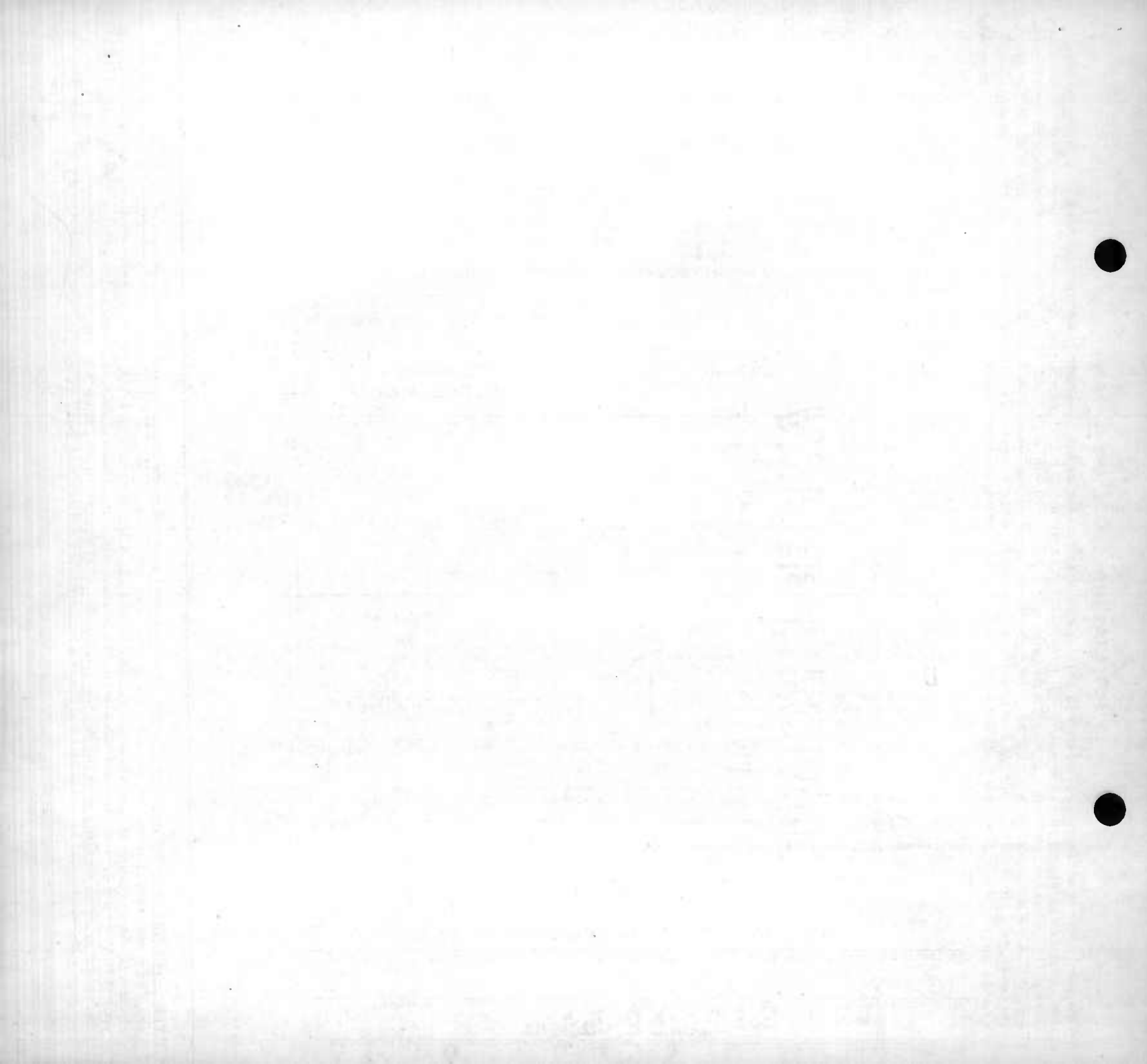
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <span style="font-size: 1.5em;">X</span> 66 09945	
BIRTH NO. <span style="font-size: 1.2em;">65-1037066</span> 09945							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Lehorah Kleinsmith</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">10-2-66</span>		<span style="font-size: 1.2em;">2<sup>30</sup></span> P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		<span style="font-size: 1.2em;">Balt. County</span>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">Children's Hospital, Balt. Md</span>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Balt. 28, Md.</span>		<span style="font-size: 1.2em;">53-00</span>	
				D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">7008 Eastbrook Ave</span>			
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <span style="font-size: 1.2em;">7/3/65</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">1 yr.</span>	10. Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore Md.</span>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <span style="font-size: 1.2em;">Robert Kleinsmith</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Joan L. Steinach</span>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Robert Kleinsmith 7008 Eastbrook Ave</span>		
18. <span style="font-size: 1.2em;">756.21</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <span style="font-size: 1.2em;">BILIARY CIRRHOSIS</span> DUE TO (B) <span style="font-size: 1.2em;">BILIARY ATRESIA</span> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">MONTHS.</span>  <span style="font-size: 1.2em;">MONTHS.</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">BILIARY ATRESIA</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">- NO -</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(this hospital)</u> attended the deceased from <span style="font-size: 1.2em;">18 AUGUST</span> 19 <span style="font-size: 1.2em;">66</span> to <span style="font-size: 1.2em;">2 OCT</span> 19 <span style="font-size: 1.2em;">66</span> , that <u>(we)</u> lost saw the deceased alive on <span style="font-size: 1.2em;">2 OCT</span> 19 <span style="font-size: 1.2em;">66</span> and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">John P. Remensnyder</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">2 OCT 1966</span>			
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">JOHN P. REMENSNYDER M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">CHILDREN'S HOSPITAL - BALTIMORE, MD.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">10-4-66</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holy Rosary</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 4 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farkner</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Walter H. Harkowski</span>		ADDRESS <span style="font-size: 1.2em;">1005 S. ...</span>	



H-600

66 09946

BALTIMORE CITY HEALTH DEPARTMENT

66 09946

BIRTH NO. 66-02894		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 66 09946	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) PAUL AARON HEIER			2. DATE AND HOUR PRONOUNCED DEAD September 27, 1966 7:35 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 St. Agnes Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balt. County C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5602 Huntsmoor Road		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH Feb. 11, 1966	9. AGE (In years last birthday) 7	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME JAMES M. HEIER			14. MOTHER'S MAIDEN NAME MARVA L. STILL		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 5606 HUNTS MOOR Rd. MRS. MARVA L. HEIER	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Head Injuries DUE TO INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5602 Huntsmoor Road	
21D. TIME OF INJURY (APPROX.) 9 27 '66		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Battered Child	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/28/66					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE Oct. 3, 1966		23C. NAME OF CEMETERY or CREMATORY BALTO. NATIONAL CEM. BALTO. MD.	
24A. DATE REC'D BY HEALTH DEPT. OCT 4 1966		24B. NAME OF REGISTRAR Robert E. Farber		24C. FUNERAL DIRECTOR G. TRUMAN SCHWAB	
				ADDRESS BALTO. 29. Ave.	

WALTON  
FROM

FEB 11 1911

James M. Heiser

Mr. James M. Heiser  
2525 Broadway  
New York 1, N.Y.

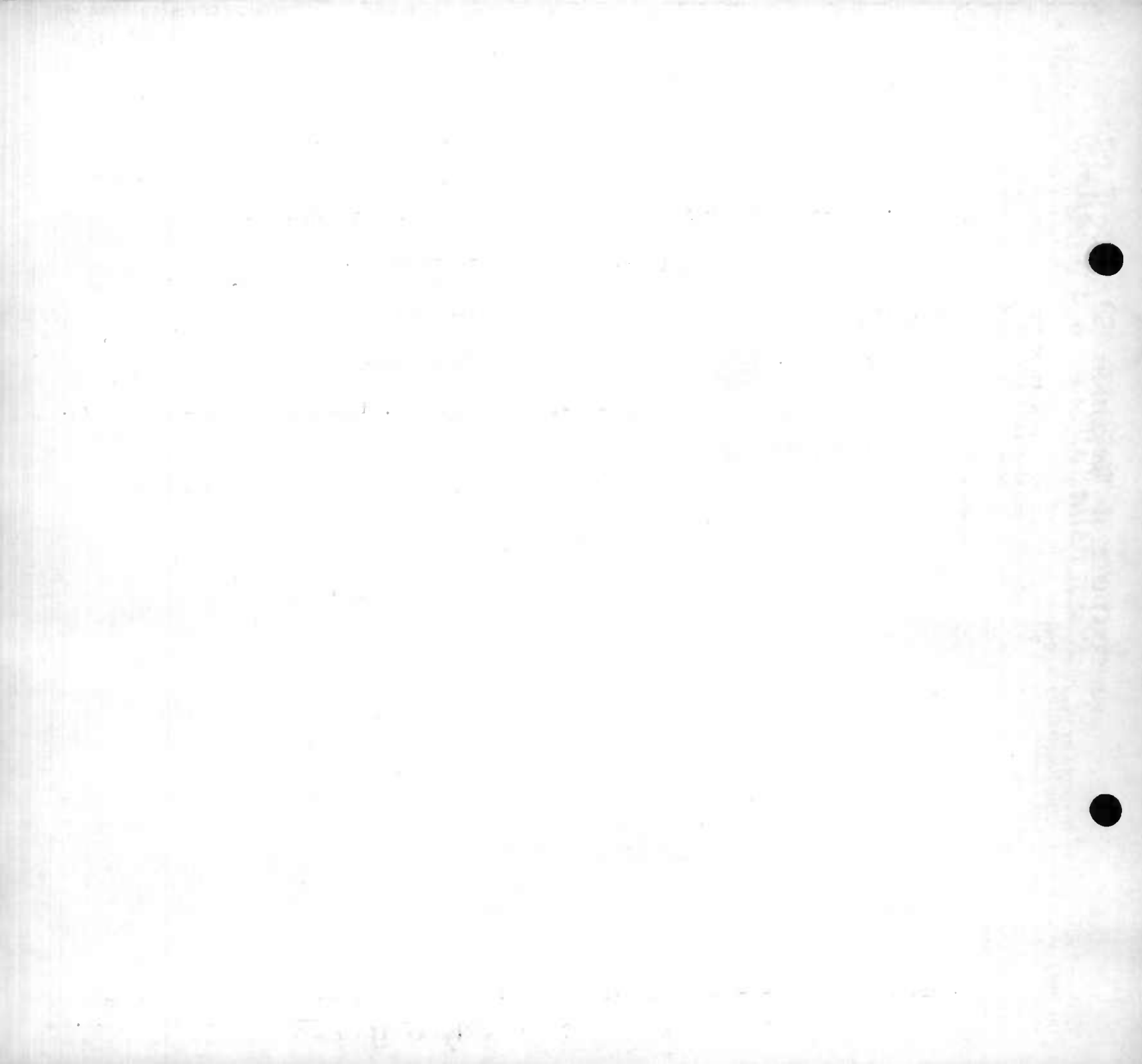
Box 11  
Ottawa, Ontario, Canada



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 09947	
BIRTH NO. 66 09947										CERTIFICATE OF DEATH	
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <b>CHARLES Simmons</b>										2. DATE AND HOUR OF DEATH <b>9/30 16<sup>25</sup> A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42. Sinai Hospital</b>										A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
										D. STREET ADDRESS (If rural, give location) <b>3624 Milford Mill Road</b>	
5. SEX <b>M</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>		8. DATE OF BIRTH <b>3-29-1885</b>		9. AGE (In years lost birthday) <b>81</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas W. Simmons</b>						14. MOTHER'S MAIDEN NAME <b>Annie Heaps</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214-10-6806</b>		17. INFORMANT ADDRESS <b>Charles E. Simmons 4103 Hayward Ave.</b>					
18. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) CARCINOMA OF PROSTATE WITH WIDESPREAD METASTASES.</b>											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(B) DUE TO</b> <b>(C)</b>											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/25</b> 19 <b>66</b> to <b>9/30</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/30</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>James Sobel</b> M.D.										23B. DATE SIGNED <b>9/30/66</b>	
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>10-3-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Lakeview Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>				25C. FUNERAL DIRECTOR ADDRESS <b>4600 Liberty Hghts.</b>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 09948		CERTIFICATE OF DEATH		Registered No. 66 09948	
1. NAME OF DECEASED (Type or Print) <b>HARCUM, LLOYD F.</b>				2. DATE AND HOUR OF DEATH <b>OCT. 3 0:30 AM</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE UNION MEMORIAL HOSPITAL 44 33RD AND CALVERT ST., BALTIMORE, MD</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balts. County</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>LUTHERVILLE 53-00</b> D. STREET ADDRESS (If rural, give location) <b>9 GREENRIDGE ROAD</b>					
5. SEX <b>M</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED SINGLE</b>	8. DATE OF BIRTH <b>01-12-85</b>		9. AGE (In years last birthday) <b>81</b>		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>			11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL HARCUM</b>			14. MOTHER'S MAIDEN NAME <b>SARAH ELMIRA SHELTON</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>067-03-0409</b>		17. INFORMANT ADDRESS <b>Mila Wilson Maxfield 9 Greenridge Rd.</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>3-76X I</b>				CAUSE OF DEATH (A) <b>BILATERAL PNEUMOTHORAX</b> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) <b>PERITONITIS DUE TO PERFORATION OF VISCUS</b> DUE TO				<b>3 DAYS ?</b>	
(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>OCT 1 1966</b> to <b>OCT 3 1966</b> , that (I) (we) last saw the deceased alive on <b>OCT 3 19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>P.M. Chang</b>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>OCT 3, 66</b>	
23C. PHYSICIAN'S NAME (Type) <b>PONG MOON CHANG, GEORGE MINNEY Sr.</b>						23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-5-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>			25C. FUNERAL DIRECTOR ADDRESS <b>4600 Liberty Hghts.</b>			

10/11/81

OCT 3

THANK YOU VERY MUCH

(continued)

INTERVIEW

THE CLINICAL RECORDS  
3330 AND CALVERT ST. BALTIMORE, MD

9 DECEMBER 1981

01-12-81

MARRIED

WHITE M

U S A

VIRGINIA

RETIRED

SARAH CLARK SHELTON

SARAH H. ARWIN

9

BILATERAL PRESBYOPIA

PROSTHESIS

PERIOPHTHALMIS DUE TO  
OR VISCUS

NO

OCT 3

88

OCT 8

OCT 3

OCT 3 1981

X

PH N T

RECEIVED

BIRTH NO.		M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
66 09949		66 09949							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD					
ROYAL R. HIGHTOWER				September 29, 1966				2:00 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland				B. COUNTY Baltimore	
Baltimore City Hospitals				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)				Baltimore — Dundalk 53-00	
31				D. STREET ADDRESS (If rural, give location)				21222	
2706 McComas Avenue									
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White		Married		Sept. 5- 1927		39	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)	
Chief Mate,				Calmar Steamship Corp.				North Carolina	
12. CITIZEN OF WHAT COUNTRY?								U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Halon Hightower				Alta Beck					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes, Army, 1954-56				244-28-1542		Wife, Mrs. Lillian M. Hightower, #4, a, b, c, d.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) Multiple Traumatic Injuries.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2						Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
				Street		Boston St., W. of Angelsea St. 26-36			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
9 29 '66 P M.				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Driver of auto which struck truck.			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE				M.D.				DATE SIGNED	
EXAMINER'S NAME (Type)				Charles S. Petty, M.D.				9/30/66	
23A. BURIAL CREMATION, REMOVAL (Specify)				23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial				Oct-3-1966		Holly Hill		Thomasville, North Carolina	
24A. DATE REC'D BY HEALTH DEPT.				24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS			
OCT 4 1966				Robert E. Farley, Jr.		JOHN J. DUDA, Dundalk, Maryland 21222			

WALLER FORGIE

U.S.A.      1907-1908      1909-1910      1911-1912      1913-1914      1915-1916      1917-1918      1919-1920      1921-1922      1923-1924      1925-1926      1927-1928      1929-1930      1931-1932      1933-1934      1935-1936      1937-1938      1939-1940      1941-1942      1943-1944      1945-1946      1947-1948      1949-1950      1951-1952      1953-1954      1955-1956      1957-1958      1959-1960      1961-1962      1963-1964      1965-1966      1967-1968      1969-1970      1971-1972      1973-1974      1975-1976      1977-1978      1979-1980      1981-1982      1983-1984      1985-1986      1987-1988      1989-1990      1991-1992      1993-1994      1995-1996      1997-1998      1999-2000      2001-2002      2003-2004      2005-2006      2007-2008      2009-2010      2011-2012      2013-2014      2015-2016      2017-2018      2019-2020      2021-2022      2023-2024      2025-2026      2027-2028      2029-2030      2031-2032      2033-2034      2035-2036      2037-2038      2039-2040      2041-2042      2043-2044      2045-2046      2047-2048      2049-2050      2051-2052      2053-2054      2055-2056      2057-2058      2059-2060      2061-2062      2063-2064      2065-2066      2067-2068      2069-2070      2071-2072      2073-2074      2075-2076      2077-2078      2079-2080      2081-2082      2083-2084      2085-2086      2087-2088      2089-2090      2091-2092      2093-2094      2095-2096      2097-2098      2099-2100      2101-2102      2103-2104      2105-2106      2107-2108      2109-2110      2111-2112      2113-2114      2115-2116      2117-2118      2119-2120      2121-2122      2123-2124      2125-2126      2127-2128      2129-2130      2131-2132      2133-2134      2135-2136      2137-2138      2139-2140      2141-2142      2143-2144      2145-2146      2147-2148      2149-2150      2151-2152      2153-2154      2155-2156      2157-2158      2159-2160      2161-2162      2163-2164      2165-2166      2167-2168      2169-2170      2171-2172      2173-2174      2175-2176      2177-2178      2179-2180      2181-2182      2183-2184      2185-2186      2187-2188      2189-2190      2191-2192      2193-2194      2195-2196      2197-2198      2199-2200      2201-2202      2203-2204      2205-2206      2207-2208      2209-2210      2211-2212      2213-2214      2215-2216      2217-2218      2219-2220      2221-2222      2223-2224      2225-2226      2227-2228      2229-2230      2231-2232      2233-2234      2235-2236      2237-2238      2239-2240      2241-2242      2243-2244      2245-2246      2247-2248      2249-2250      2251-2252      2253-2254      2255-2256      2257-2258      2259-2260      2261-2262      2263-2264      2265-2266      2267-2268      2269-2270      2271-2272      2273-2274      2275-2276      2277-2278      2279-2280      2281-2282      2283-2284      2285-2286      2287-2288      2289-2290      2291-2292      2293-2294      2295-2296      2297-2298      2299-2300      2301-2302      2303-2304      2305-2306      2307-2308      2309-2310      2311-2312      2313-2314      2315-2316      2317-2318      2319-2320      2321-2322      2323-2324      2325-2326      2327-2328      2329-2330      2331-2332      2333-2334      2335-2336      2337-2338      2339-2340      2341-2342      2343-2344      2345-2346      2347-2348      2349-2350      2351-2352      2353-2354      2355-2356      2357-2358      2359-2360      2361-2362      2363-2364      2365-2366      2367-2368      2369-2370      2371-2372      2373-2374      2375-2376      2377-2378      2379-2380      2381-2382      2383-2384      2385-2386      2387-2388      2389-2390      2391-2392      2393-2394      2395-2396      2397-2398      2399-2400      2401-2402      2403-2404      2405-2406      2407-2408      2409-2410      2411-2412      2413-2414      2415-2416      2417-2418      2419-2420      2421-2422      2423-2424      2425-2426      2427-2428      2429-2430      2431-2432      2433-2434      2435-2436      2437-2438      2439-2440      2441-2442      2443-2444      2445-2446      2447-2448      2449-2450      2451-2452      2453-2454      2455-2456      2457-2458      2459-2460      2461-2462      2463-2464      2465-2466      2467-2468      2469-2470      2471-2472      2473-2474      2475-2476      2477-2478      2479-2480      2481-2482      2483-2484      2485-2486      2487-2488      2489-2490      2491-2492      2493-2494      2495-2496      2497-2498      2499-2500      2501-2502      2503-2504      2505-2506      2507-2508      2509-2510      2511-2512      2513-2514      2515-2516      2517-2518      2519-2520      2521-2522      2523-2524      2525-2526      2527-2528      2529-2530      2531-2532      2533-2534      2535-2536      2537-2538      2539-2540      2541-2542      2543-2544      2545-2546      2547-2548      2549-2550      2551-2552      2553-2554      2555-2556      2557-2558      2559-2560      2561-2562      2563-2564      2565-2566      2567-2568      2569-2570 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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 09950					CERTIFICATE OF DEATH			Registered No. 66 09950	
1. NAME OF DECEASED (Type or Print) <b>Nelson, Arthur Waldorf</b>					2. DATE AND HOUR OF DEATH <b>2:05 PM. Oct 2, 1966</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Union Memorial Hospital</b>					A. STATE <b>Maryland</b> B. COUNTY <b>HARFORD</b>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>FALLSTON</b>				
					D. STREET ADDRESS (If rural, give location) <b>Route #2 Box 197</b>				
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>02-11-06</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>BRIDGE</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>			12. CITIZEN OF WHAT COUNTRY? <b>American</b>	
13. FATHER'S NAME <b>George Nelson</b>					14. MOTHER'S MAIDEN NAME <b>Caroline Anderson</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-14-9886</b>		17. INFORMANT <b>Mrs. Anna E. Nelson</b>			ADDRESS <b>Same as above</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>					INTERVAL BETWEEN ONSET AND DEATH <b>80 hours</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <b>Sept 29</b> 19 <b>66</b> to <b>Oct-2</b> 19 <b>66</b> , that (I) ( <u>we</u> ) lost saw the deceased olive on <b>2:05 PM. Oct 2</b> 19 <b>66</b> and that in ( <u>my</u> ) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>We</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.									
23A. SIGNATURE <b>Sang Won Song</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>Oct-2, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>SANG WON SONG</b>					23D. ADDRESS M.D. <b>THE UNION MEMORIAL HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/5/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>EBENEZER</b>			24D. LOCATION (City, town, or county) (State) <b>ROTLIDGE MARYLAND</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Talley</b>			25C. FUNERAL DIRECTOR ADDRESS <b>CHARLES E. KURTZ JARRETSVILLE, MD.</b>			

WATERFORD

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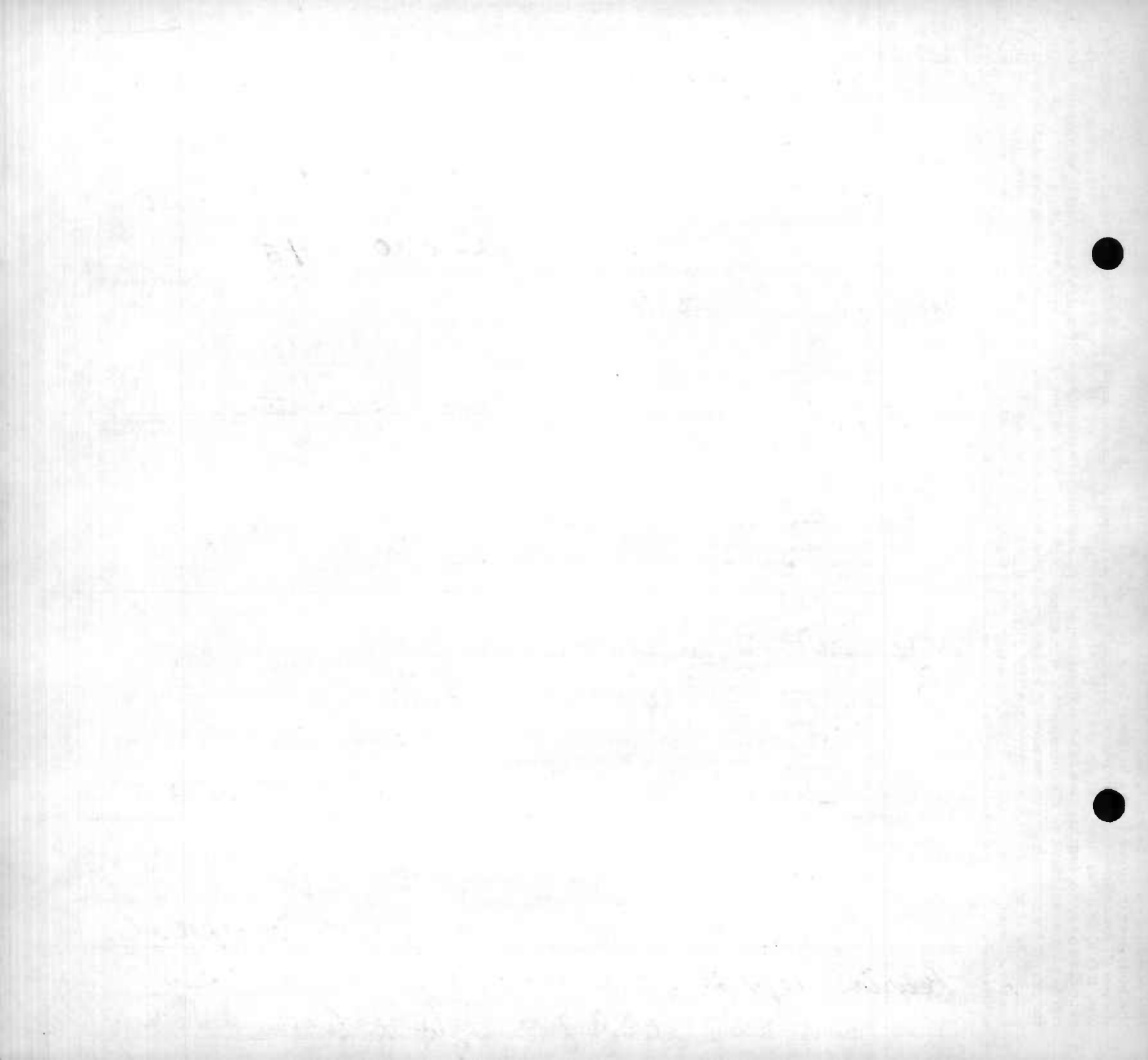


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09951				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09951	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Hilton Dudley E.</i>				2. DATE AND HOUR OF DEATH <i>10-2-66</i>   <i>5:40</i> / <i>A</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hosp.</i>				A. STATE <i>md.</i>			
(If not in hospital or institution, give street, address or location)				B. COUNTY			
5. SEX <i>M</i>				6. RACE <i>W</i>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>				8. DATE OF BIRTH <i>12-20-20</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>auto</i>			
11. BIRTHPLACE (State or foreign country) <i>md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Fred. Hilton (dec.)</i>				14. MOTHER'S MAIDEN NAME <i>Lillian Appleby (dec.)</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes</i> ?				16. SOCIAL SECURITY NO. <i>?</i>			
17. INFORMANT <i>Mrs Doris Hilton</i>				ADDRESS <i>above</i>			
18. <i>581.1</i> I				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) <i>gastrointestinal hemorrhage</i> DUE TO <i>bleeding varices</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>chronic alcoholic cirrhosis</i> DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) <i>jaundice 2° (B)</i>			
19A. DATE OF OPERATION <i>2</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <i>yes</i>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10/2/66</i> 19 to <i>10/2/66</i> 19, that (I) (we) last saw the deceased alive on <i>10/2/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>D. E. Colston</i>				23B. DATE SIGNED <i>10/2/66</i>			
23C. PHYSICIAN'S NAME (Type) <i>A. C. Colston</i>				23D. ADDRESS <i>University Hospital</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>10/4/66</i>			
24C. NAME OF CEMETERY or CREMATORY <i>Eden Haven Cem.</i>				24D. LOCATION (City, town, or county) (State) <i>Ritchie Hwy Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 4 1966</i>				25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>			
25C. FUNERAL DIRECTOR <i>John J. Cowan &amp; Son Inc.</i>				ADDRESS <i>411 St. Hollins 23 Md.</i>			

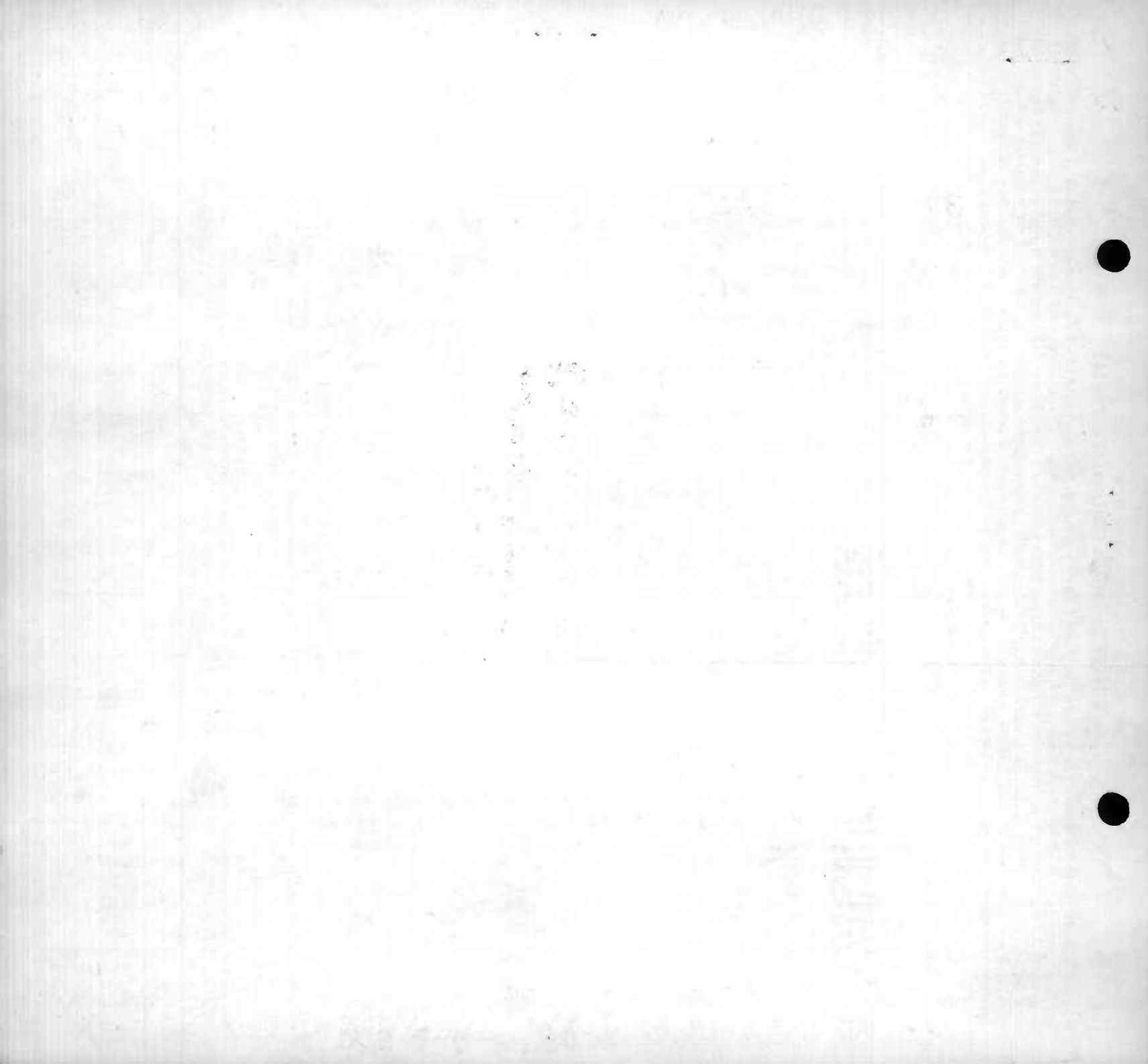




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09952		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09952	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Taylor, Walter Roland.		2. DATE AND HOUR OF DEATH Oct. 2, 1966. 12 <sup>30</sup> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 36 Franklin Square Hospital		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 23-01 D. STREET ADDRESS (If rural, give location) 1414 Clarkson St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-5-72	9. AGE (in years last birthday) 54	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Disabled
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Elec. Ins. Co.	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Walter P. Taylor		14. MOTHER'S MAIDEN NAME Estella Howser			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS Hospital chart.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) EXSANGUINATION due to c/f bleeding for about 1 month. peptic ulcer, probably 1 mo. Steroid therapy		CAUSE OF DEATH (A) DUE TO (B) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1414 Clarkson Street 23-01	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) Approx. one (1) Mo.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Complication of long term steroid therapy	
22. I certify that (I) (this hospital) attended the deceased from Oct. 2, 1966 to Oct. 2, 1966, that (I) (we) last saw the deceased alive on Oct. 2, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE K. B. Lee		23B. DATE SIGNED Oct. 2, 1966	
23C. PHYSICIAN'S NAME (Type) Ki Bum Lee		23D. ADDRESS Franklin Square Hospital			
24A. BURIAL, CREMATION, REMOVAL (Specify) 10-6-66		24B. DATE 10-6-66		24C. NAME OF CEMETERY or CREMATORY Lakeview	
24D. LOCATION (City, town, or county) (State) Balt. Carroll Co, Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 4 1966		25B. NAME OF REGISTRAR R. E. F. F. F.	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

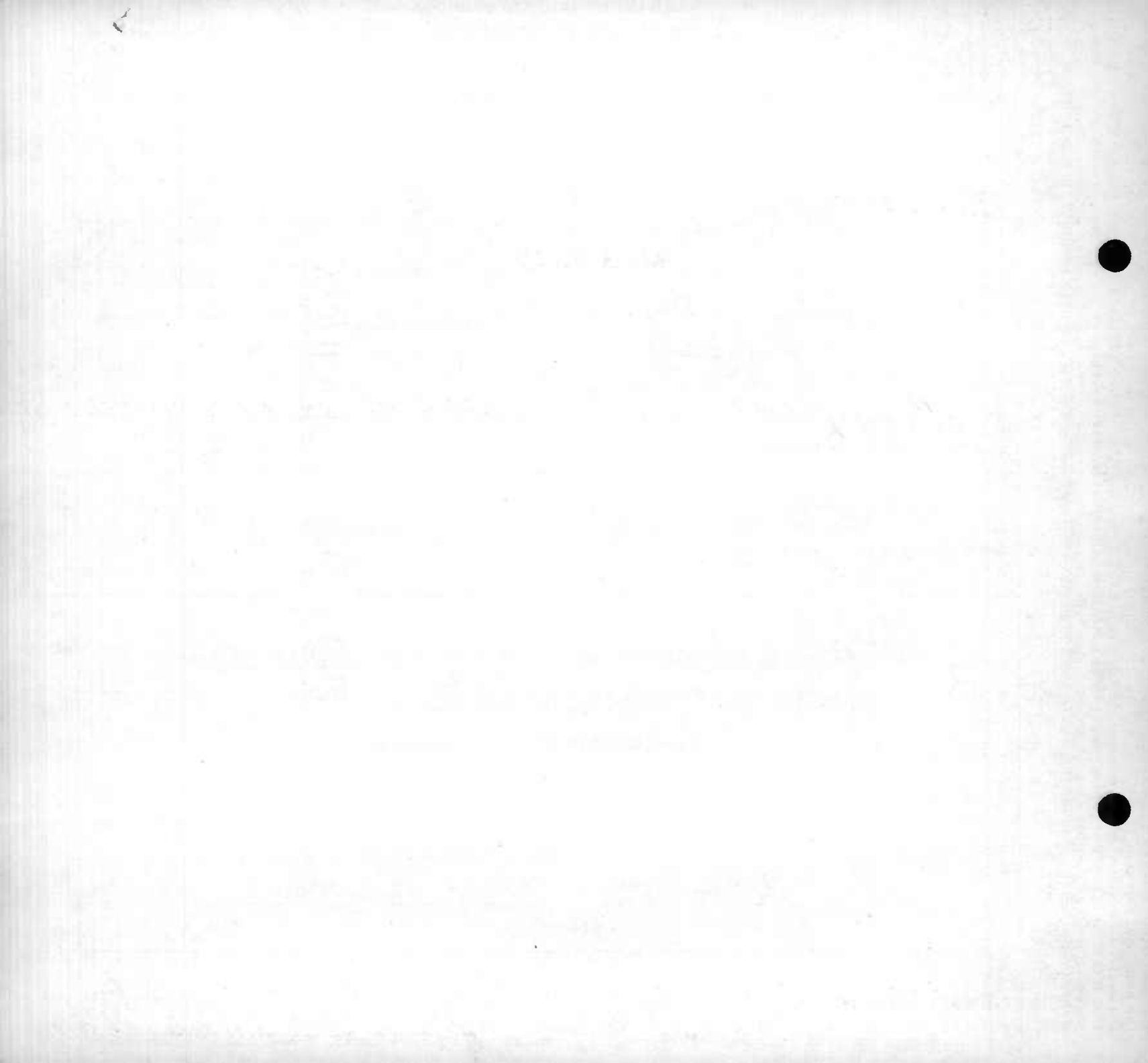
BIRTH NO. 66 09953				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 09953	
1. NAME OF DECEASED (Type or Print) <b>MATIE GERTRUDE KEISER</b>				2. DATE AND HOUR OF DEATH <b>10/1/66 7:30 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <del>BALTIMORE CITY HOSPITAL</del> FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE MARYLAND 21224</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto. County</b> D. STREET ADDRESS (If rural, give location) <b>1320 WILSON POINT ROAD - 21220</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>6/24/74</b>	9. AGE (In years last birthday) <b>92</b>	If Under 1 Yr. Months Days Hours Min.		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>IOWA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JOSEPH</b>			14. MOTHER'S MAIDEN NAME <b>ADALINE Smith</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>214-50-2041</b>		17. INFORMANT <b>RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCT</b>				CAUSE OF DEATH (A) <b>MYOCARDIAL INFARCT</b> DUE TO (B) <b>ARTERIOSCLEROTIC HEART DISEASE 30 years</b> DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <b>10/1</b> 19 <b>66</b> to <b>10/1</b> 19 <b>66</b> . that (1) (we) last saw the deceased alive on <b>10/1</b> 19 <b>66</b> and that (1) (my) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Judith Hall</b>				M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/1/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>JUDITH HALL</b>				23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> M.D. <b>4940 EASTERN AVENUE, BALTIMORE, Md. 21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>OCT 6, 1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Wall Lake Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Wall Lake, Iowa</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>		25C. FUNERAL DIRECTOR <b>Polio E. Guay</b>		ADDRESS <b>1211 Chesaco Ave.</b>			

WASH. STATE  
UNIVERSITY OF WASHINGTON

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 09954				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09954	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FLYNN, URATH K				2. DATE AND HOUR OF DEATH 10.2.66 14:00 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV. HOSPITAL, BALTIMORE				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 1814 WILHELM ST.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED		8. DATE OF BIRTH 12.23.97	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10B. KIND OF BUSINESS OR INDUSTRY DEPT. STORE		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES H. FLYNN WILLY				14. MOTHER'S MAIDEN NAME MATILDA FLYNN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT LEO C. FLYNN 1814 WILHELM ST.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH A. DUE TO CA OF HEAD OF PANCREAS NO HISTO. DX.				INTERVAL BETWEEN ONSET AND DEATH ?			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				B. DUE TO C. DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 10		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9.22.66 19 to 10.2 1966, that (I) (we) last saw the deceased alive on 10.2.66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stuart L Fine MD				23B. DATE SIGNED 10.2.66		23C. PHYSICIAN'S NAME (Type) STUART L. FINE M.D.	
23D. ADDRESS UNIV. HOSP., BALTIMORE, MD.				23E. FURNAL DIRECTOR Geo. L. Schwab Funeral Home Francis H. Miller 2101 Hudson Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-6-66		24C. NAME OF CEMETERY or CREMATORY Loudon PARK		24D. LOCATION (City, town, or county) (State) BALTIMORE, Md	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FURNAL DIRECTOR Geo. L. Schwab Funeral Home Francis H. Miller 2101 Hudson Ave.			

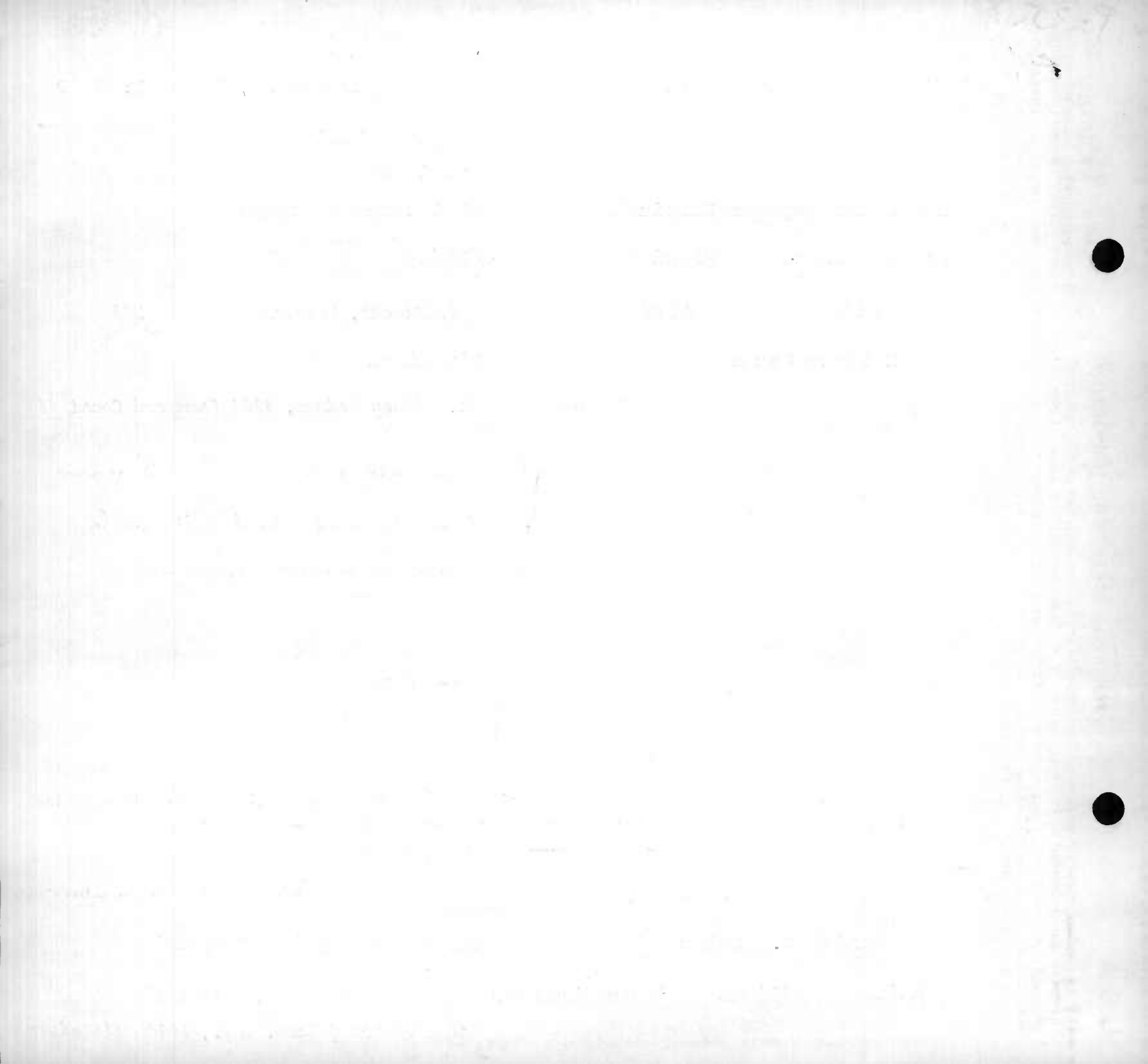


FUNERAL DIRECTOR: IMPORTANT

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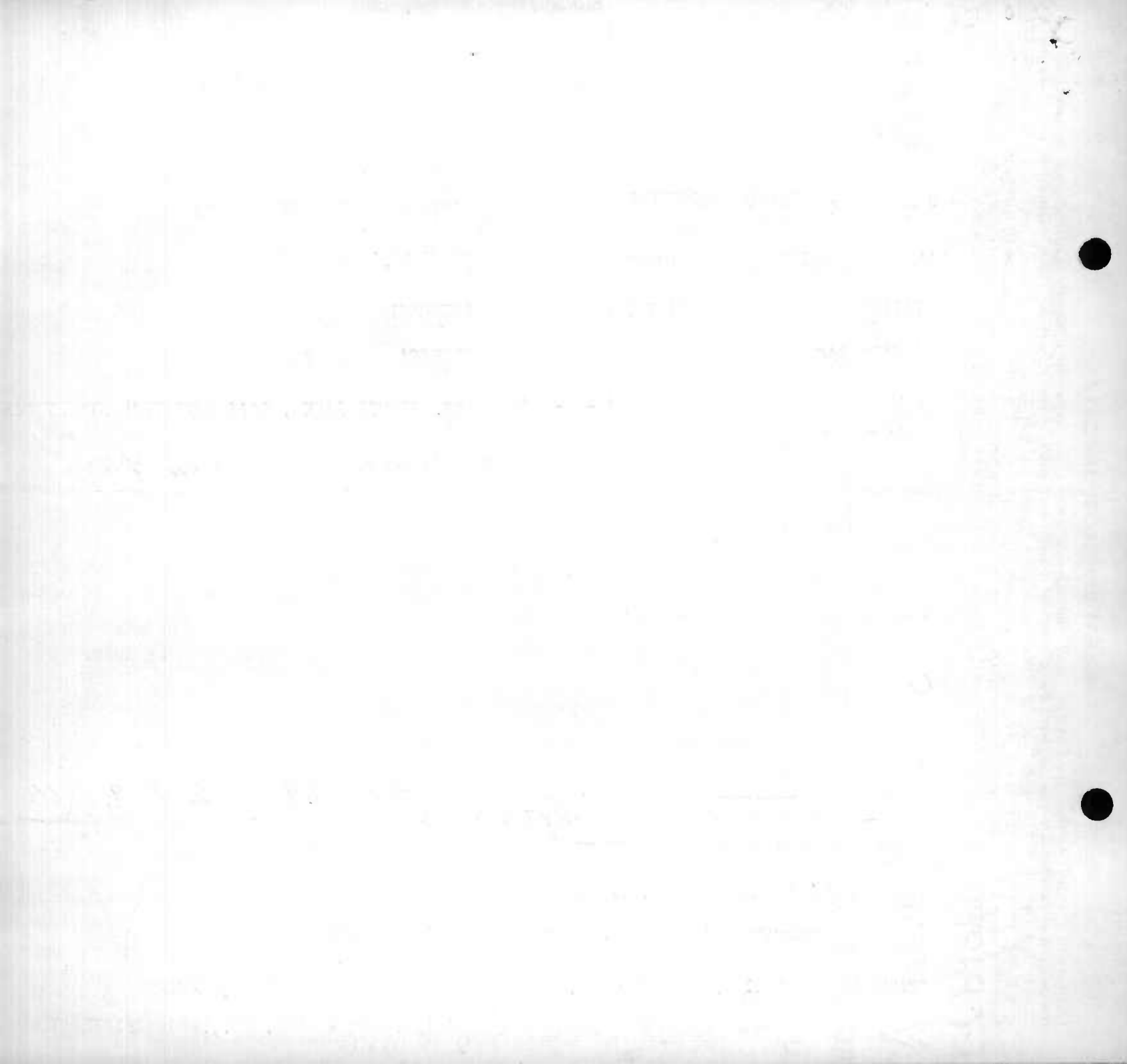
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09955</u>	
BIRTH NO. <u>66 09955</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Sylvia Rodman</u>		2. DATE AND HOUR OF DEATH <u>September 30, 1966</u> <u>2:00</u> P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> 21208 <u>Balto. County</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>8204 Cranwood Court</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> <u>The Johns Hopkins Hospital</u>					
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>8/26/19</u>	9. AGE (In years last birthday) <u>47</u>	II Under 1 Yr. Months Days II Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Isadore Sachs</u>		14. MOTHER'S MAIDEN NAME <u>Ada Kirsch</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mr. Sidney Rodman, 8204 Cranwood Court #8</u>	
18. <u>200.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>reticulum cell sarcoma</u> DUE TO (B) <u>metastases to head, chest wall, neck,</u> DUE TO (C) <u>epigastrium, abdomen, spine</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>29 September 1966</u> to <u>30 September 1966</u> , that (we) lost saw the deceased alive on <u>2 PM 30 September 1966</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Daniel C. Hadlock</u>				23B. DATE SIGNED <u>30 September 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Daniel C. Hadlock</u>		23D. ADDRESS <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/2/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Hebrew Young Men</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 3 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09956	
BIRTH NO. 66 09956				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MORRIS SACKS		SEPTEMBER 29, 1966 2 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION  34 BON SECOURS HOSPITAL				A. STATE MARYLAND	
(If not in hospital or institution, give street address or location)				B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location) 2016 CHRISTIAN STREET #23	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH AUGUST 26, 1884	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10B. KIND OF BUSINESS OR INDUSTRY CLOTHING		11. BIRTHPLACE (State or foreign country) LITHUANIA	
13. FATHER'S NAME ADOLPH SACKS			12. CITIZEN OF WHAT COUNTRY? USA		
14. MOTHER'S MAIDEN NAME REBECCA ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-18-4519		17. INFORMANT MRS. JENNIE SACKS, 2016 CHRISTIAN STREET #23	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH  Arteriosclerotic C.V. Disease years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 19 64 to Sept 29, 19 66. that (I) (we) lost saw the deceased alive on Sept 23, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  Abram Goldman M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ABRAM GOLDMAN M.D.				23D. ADDRESS 4123 FREDERICK AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/2/66		24C. NAME of CEMETERY or CREMATORY BETH HANEDROSH HAGODOL	
24D. LOCATION BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. OCT 3 1966			
25A. NAME OF REGISTRAR Robert E. Goldberg		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09957	
BIRTH NO. 66 09957		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Friedlander, Jacob S.		2. DATE AND HOUR OF DEATH 9/29/66 10.45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore 42		D. STREET ADDRESS (If rural, give location) 4010 Fernhill Ave.			
5. SEX Male	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH <del>XXXXXXXXXX</del>	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR		10B. KIND OF BUSINESS OR INDUSTRY TAVERN		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME MORRIS FRIEDLANDER		14. MOTHER'S MAIDEN NAME <del>XXXXXXXXXX</del> EVELYN LEAH ?		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS MR. JEROME FRIEDLANDER, 716 CLOUDYFOLD DRIVE	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Arteriosclerotic cardiovascular disease			
		(C) DUE TO Diverticulosis complicated bleeding			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 9-6-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diverticulosis		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-4-66 19 to 9/29 1966 that (I) (we) last saw the deceased alive on 9/29 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barry Lindenbaum M.D.				23B. DATE SIGNED 9/29/66	
23C. PHYSICIAN'S NAME (Type) BARRY LINDENBAUM M.D.				23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/2/66		24C. NAME OF CEMETERY or CREMATORY BETH JACOB	
25A. DATE REC'D BY HEALTH DEPT. OCT 3 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS SOG LEVINSON & BROS. INC., 6010 REISTERSTOWN	

1952

Friedrich

Harvard

Baltimore

4010 Fennell Ave

4141

St. Joseph's Hospital

Male

W.

Male

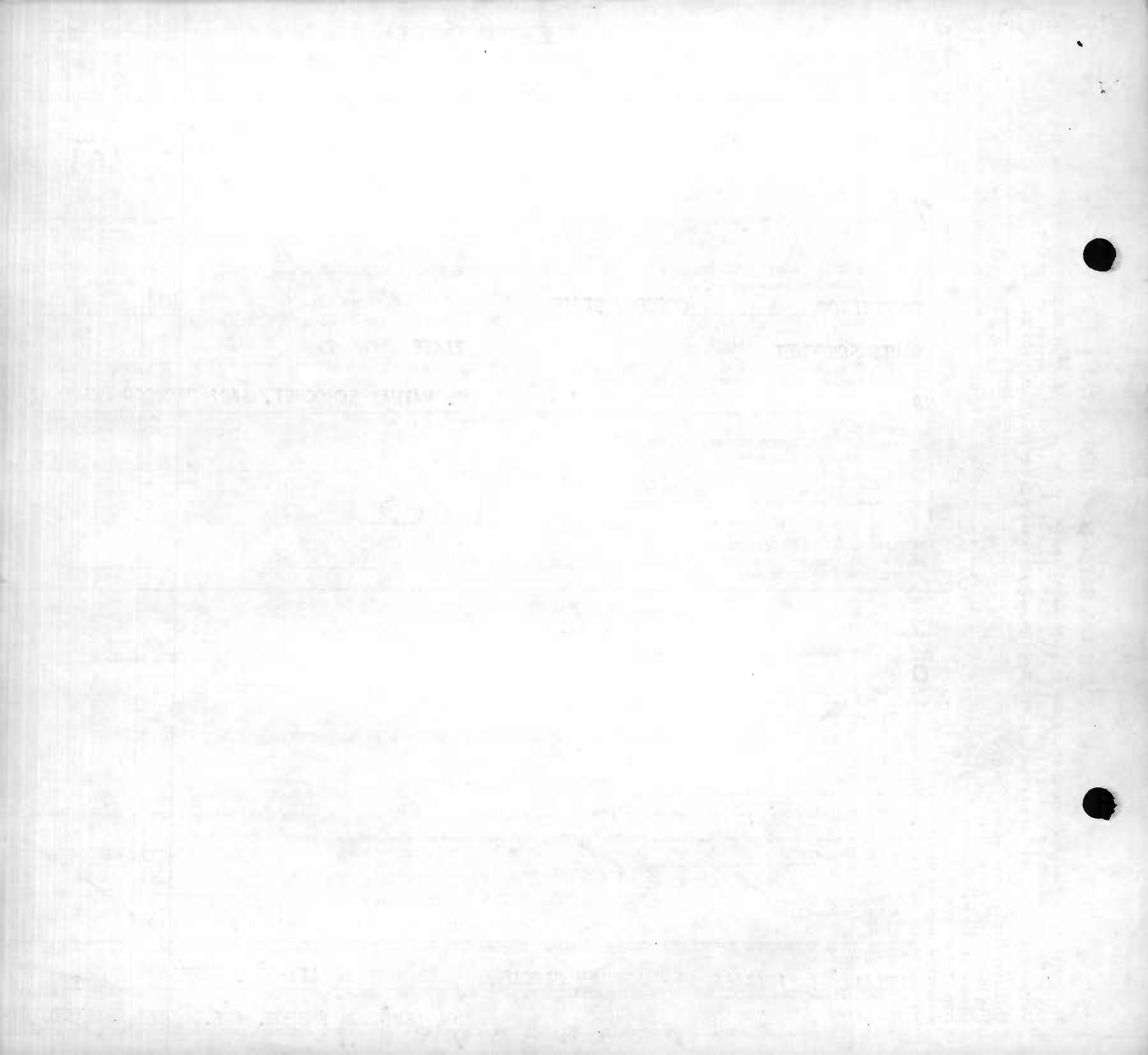
Medical Institute

Director of Hospital  
Baltimore

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09958	
BIRTH NO. 66 09958		CERTIFICATE OF DEATH		Registered No. 66 09958	
1. NAME OF DECEASED (Type or Print) Joseph Schochet			2. DATE AND HOUR OF DEATH Sept 29 1966 2 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Sinai Hospital of Baltimore FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-10 D. STREET ADDRESS (If rural, give location) 3901 Boarman Ave		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9/28/88	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR		10B. KIND OF BUSINESS OR INDUSTRY GROCERY STORE	11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME DAVID SCHOCHET			14. MOTHER'S MAIDEN NAME ZLATE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	17. INFORMANT MR. NATHAN SCHOCHET, 6801 DARWOOD DRIVE #9 ADDRESS		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) CVA DUE TO (B) ASCVD DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 week Unknown
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. History of Myocardial Infarction 1 year					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Sept 23 19 66 to Sept 29 19 66, that (I) (we) last saw the deceased alive on Sept 29 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED Sept 29 1966		
23C. PHYSICIAN'S NAME (Type) William Cieplinski M.D.			23D. ADDRESS Sinai Hospital of Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 10/2/66	24C. NAME OF CEMETERY OR CREMATORY WORKMEN CIRCLE	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. OCT 3 1966		25B. NAME OF REGISTRAR [Signature]	25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN		

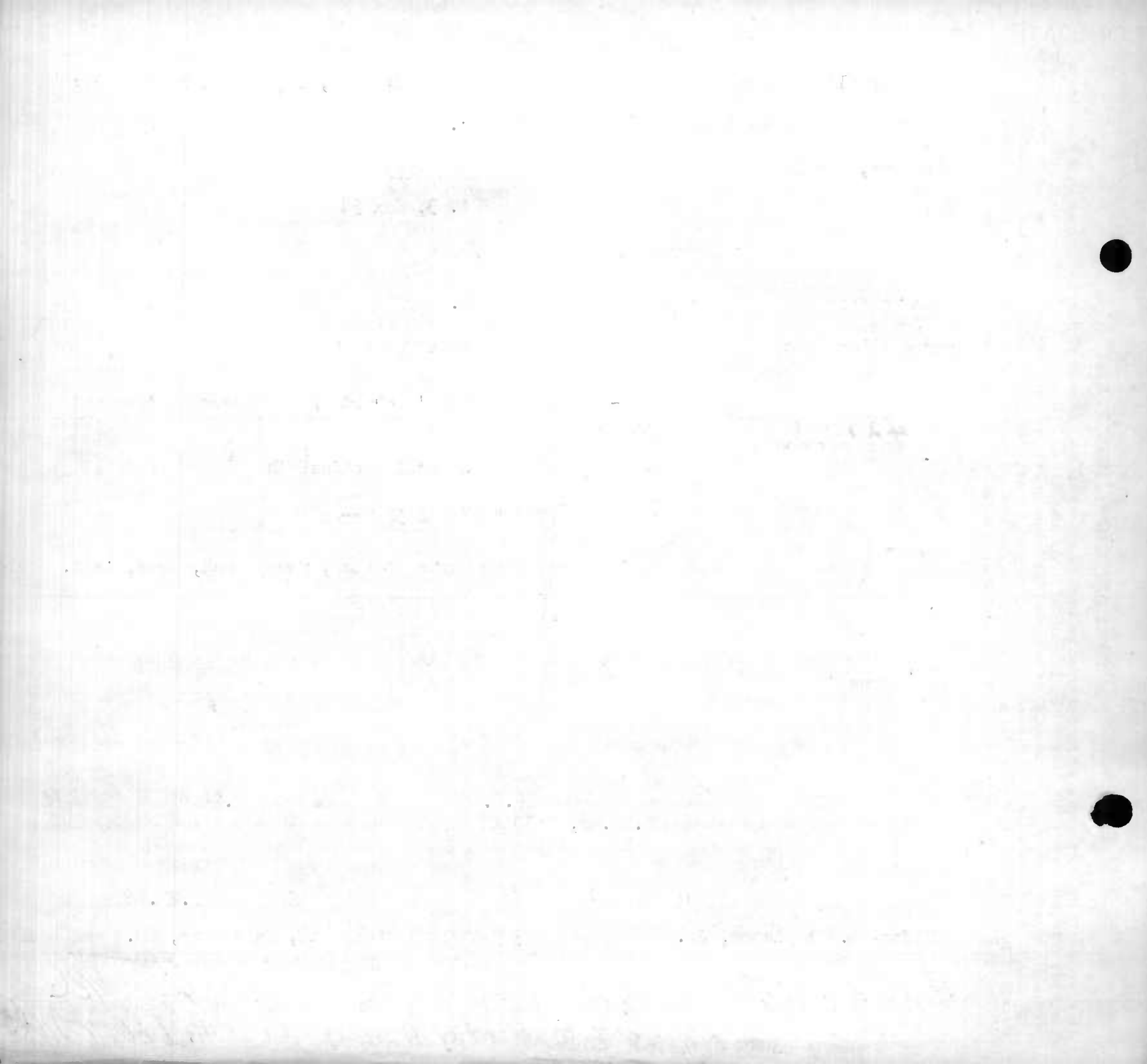


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09959		<b>CERTIFICATE OF DEATH</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09959	
1. NAME OF DECEASED (Type or Print) <b>Cornelia Tongue</b>				2. DATE AND HOUR OF DEATH <b>2:44 AM, 29 September 66</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>University of Maryland Hospital</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore, Maryland</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>9.9. County</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Annapolis</b>			
				D. STREET ADDRESS (If rural, give location) <b>Rt. 3, Box 38</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, SEPARATED</b>		8. DATE OF BIRTH <b>1/4/08</b>	9. AGE (In years lost birthday) <b>58</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>on welfare</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>on welfare</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Allen (dec)</b>				14. MOTHER'S MAIDEN NAME <b>Serina Downs</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT ADDRESS <b>Patient's chart / University Hospital</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Staphylococcal septicaemia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 d</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>30% 2° and 3° burns</b>				<b>Flash burns to back, face, neck, arms, legs.</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>							
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>back</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Back Creek 53-00</b>			
21D. TIME OF INJURY (APPROX.) <b>9/8/66 1:30 AM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Boat engine jammed &amp; exploded</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>9.8.66</b> to <b>9.29.66</b> , that (I) (we) last saw the deceased alive on <b>9.29.66, 1:30 AM</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Sidney L. Stapleton, Jr.</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9.29.66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Sidney L. Stapleton, Jr.</b>				23D. ADDRESS M.D. <b>University Hospital, Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-4-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cheswold Memorial</b>		24D. LOCATION (City, town, or county) (State) <b>Cheswold Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>10-4-66</b>		25B. NAME OF REGISTRAR <b>Robert E. Felt</b>		25C. FUNERAL DIRECTOR <b>William Reese</b>		ADDRESS <b>Cheswold Md.</b>	





Released by M.E.C. Gregory - no further action  
per Dr. Chilton

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

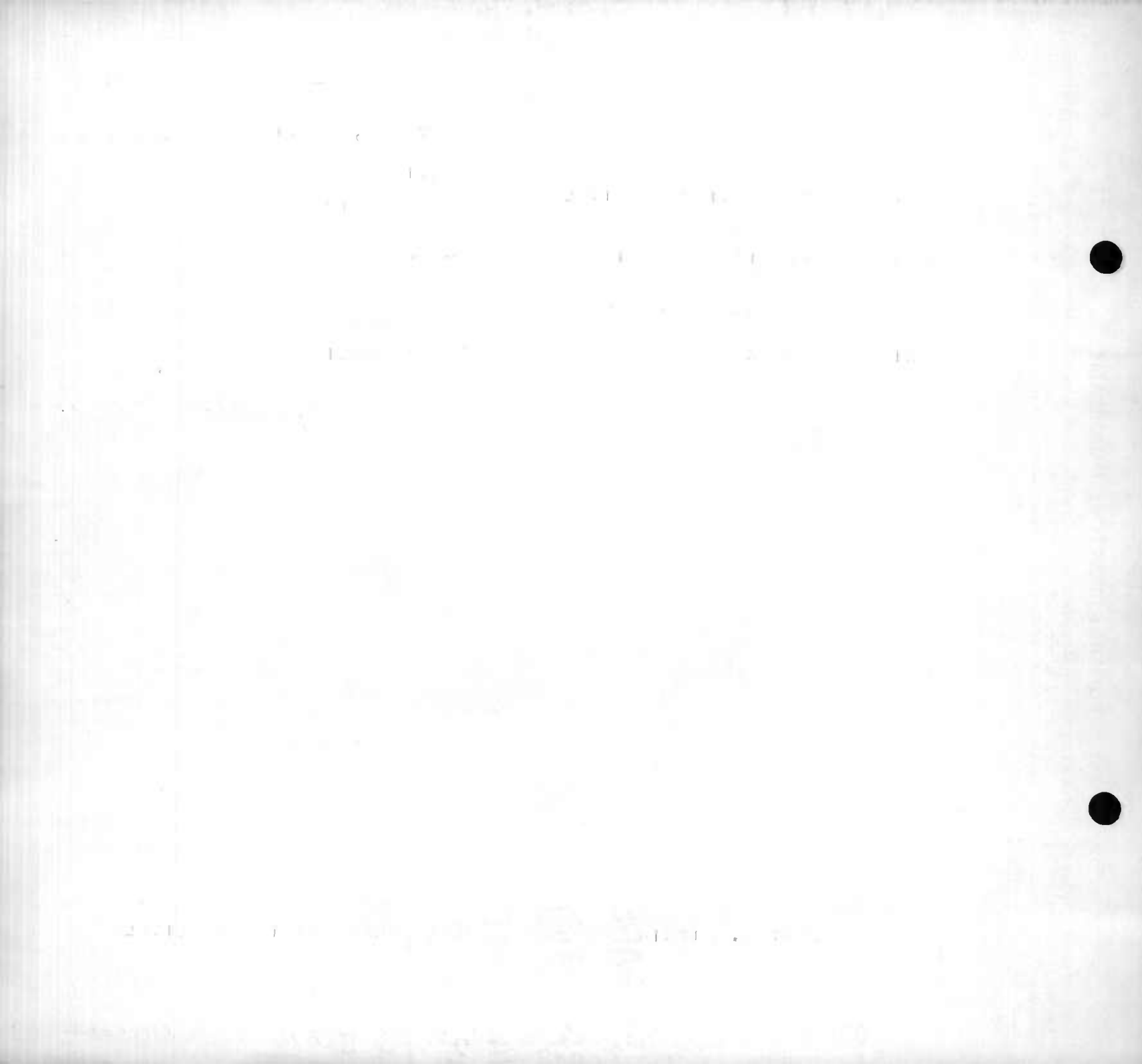
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 09960					CERTIFICATE OF DEATH			Registered No. 66 09960	
1. NAME OF DECEASED (Type or Print) <b>STOKES, EARL</b>					2. DATE AND HOUR OF DEATH <b>10/1/66 345 A M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>38/39 University Hospital</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY <b>906 W. LEXINGTON ST. Apt. 3</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE MD.</b> D. STREET ADDRESS (If rural, give location) <b>18-01</b>				
5. SEX <b>MALE</b>		6. RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never married</b>		8. DATE OF BIRTH <b>7-26-14</b>		9. AGE (In years last birthday) <b>52</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Louis Stokes</b>					14. MOTHER'S MAIDEN NAME <b>UNK.</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>					16. SOCIAL SECURITY NO. <b>420-11-4654</b>		17. INFORMANT <b>Mrs. Bessie Campbell</b> ADDRESS <b>906 W. Lexington</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease injury or complication which caused death.) <b>420.1 I</b> <b>PROBABLE MYOCARDIAL INFARCTION</b> INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>					CAUSE OF DEATH (A) DUE TO <b>ASCVD</b> (B) DUE TO (C)				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10/1/66</b> 19 to 19, that (I) (we) last saw the deceased alive on <b>D.O.A. 10/1/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Irvin M. Sopher</b> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>10/1/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Irvin M Sopher</b>					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-5-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. National Cem.</b>			24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR <b>Robert E. Taylor</b>			ADDRESS <b>1701 Laurens</b>



FUNERAL DIRECTOR: IMPORTANT

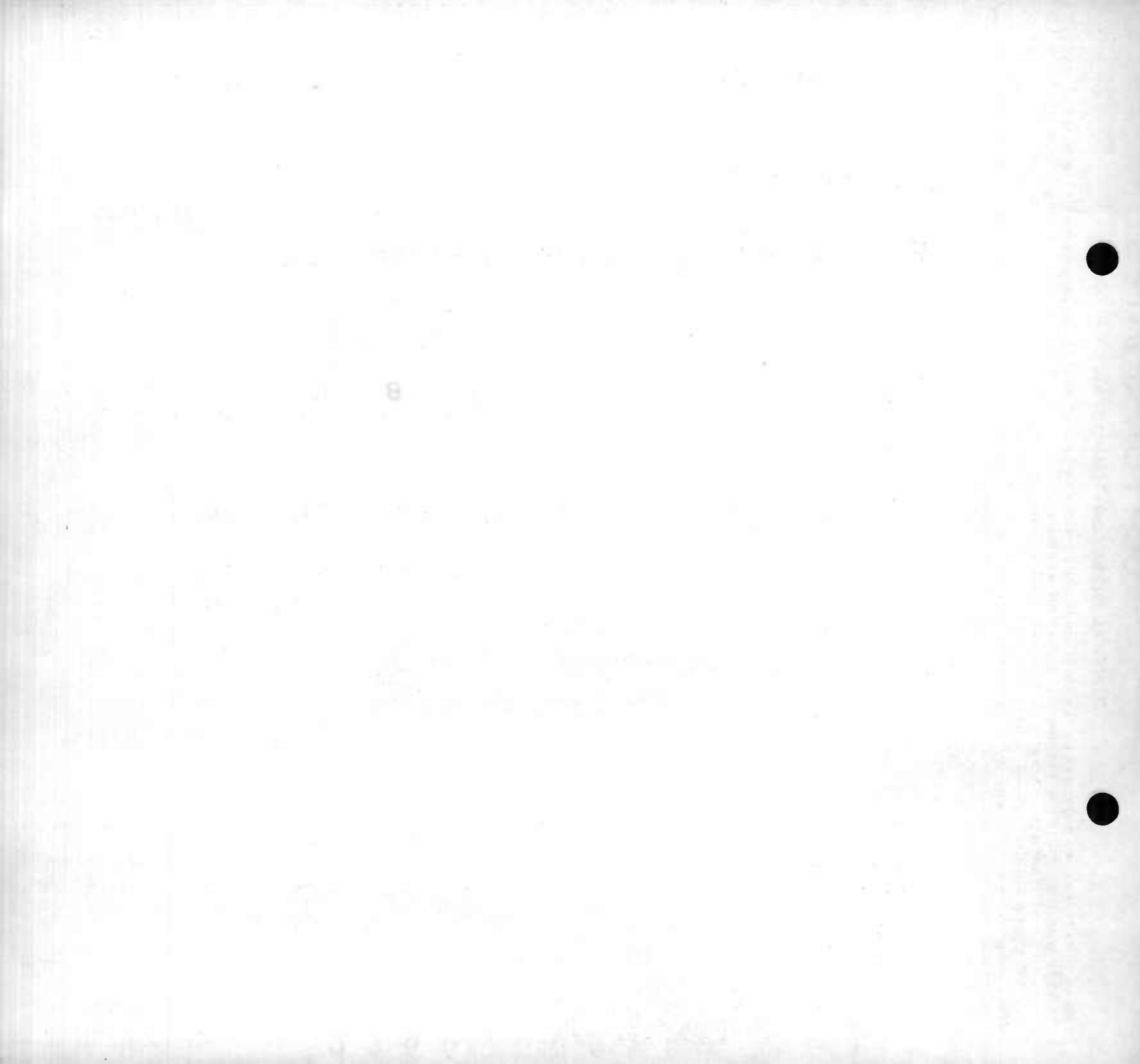
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Baltimore City Health Department		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.				66 09961		Registered No. 66 09961	
M.E. CASE NO.				66 09961		66 09961	
1. NAME OF DECEASED (Type or Print)				ELLA SHARPE		2. DATE AND HOUR OF DEATH 10-2-66 9:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY MARYLAND, BALTIMORE Baltimore County			
33 THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00			
D. STREET ADDRESS (If rural, give location) 8016 NORRIS LANE				5. SEX 6. RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) FEMALE NEGROID MARRIED			
8. DATE OF BIRTH 7-25-12				9. AGE (In years lost birthday) 54			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Home			
11. BIRTHPLACE (State or foreign country) Essex Co., VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME SKIDMORE YOUNG				14. MOTHER'S MAIDEN NAME ANNA ROZZI			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO. None			
17. INFORMANT Herbert T Sharpe				ADDRESS 8016 Norris La.			
18. 153.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Cardiac Failure following a Cardiac Arrest following an A-P respiration for Car of the Cecum			
INTERVAL BETWEEN ONSET AND DEATH 2 days between the Cardiac arrest and the death.				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. H/O Myocardial Infarction - 6 weeks Ago Moderate Hypertension			
19A. DATE OF OPERATION 3 9/29/66				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Car of Cecum			
20A. AUTOPSY? (Yes or No) Yes				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Car of Cecum			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/23/66 to 10/2/66 that (I) (we) lost saw the deceased alive on 10/2/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.				23A. SIGNATURE Robert D. Pipkin M.D.			
23B. DATE SIGNED 10/2/66				23C. PHYSICIAN'S NAME (Type) ROBERT D. PIPKIN M.D.			
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL				24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 10-6-66				24C. NAME OF CEMETERY or CREMATORY Arbutus			
24D. LOCATION Arbutus Md.				25A. DATE REC'D BY HEALTH DEPT. OCT 4 1966			
25B. NAME OF REGISTRAR P. B. & E. Johnson				25C. FUNERAL DIRECTOR MORTON + DYETT			
ADDRESS 1701 LAURENS				VS 150-REV. 1/1/65			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09962</b>	
BIRTH NO. <b>66 09962</b>		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>HOLT, LUCY</b>	
2. DATE AND HOUR OF DEATH <b>10/1/66 - 6-30 P.M.</b>		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL</b> <b>42</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>15-11</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE CITY</b> D. STREET ADDRESS (If rural, give location) <b>3704 BARRINGTON RD BALTO-15</b>	
5. SEX <b>F</b>	6. RACE <b>COLORED</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>11-7-80</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>85</b>
11. BIRTHPLACE (State or foreign country) <b>U.S.A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Mack S. Reid</b>		14. MOTHER'S MAIDEN NAME <b>Beulah</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>GLORIA BASFIELD DAUGHTER 3704 BARRINGTON RD. BALTO-15</b>
18. <b>332X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>URINARY TRACT INFECTION</b>		CAUSE OF DEATH (A) <b>PULMONARY OEDEMA</b> DUE TO <b>CEREBRAL THROMBOSIS</b> (B) <b>GANGRENE R+FOOT</b> DUE TO (C) <b>URINARY TRACT INFECTION</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>YES</b>
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>9/28/1966</b> to <b>10/1/1966</b> that <del>the</del> (we) last saw the deceased alive on <b>10/1/1966</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <del>not</del> view the body after death.			
23A. SIGNATURE <b>DR. D. K. SINGH</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>10/1/66</b>
23C. PHYSICIAN'S NAME (Type) <b>DR. D. K. SINGH</b>		23D. ADDRESS M.D. <b>SINAI HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-5-66</b>	24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR ADDRESS <b>George Kelson 1348 N. Calhoun St.</b>

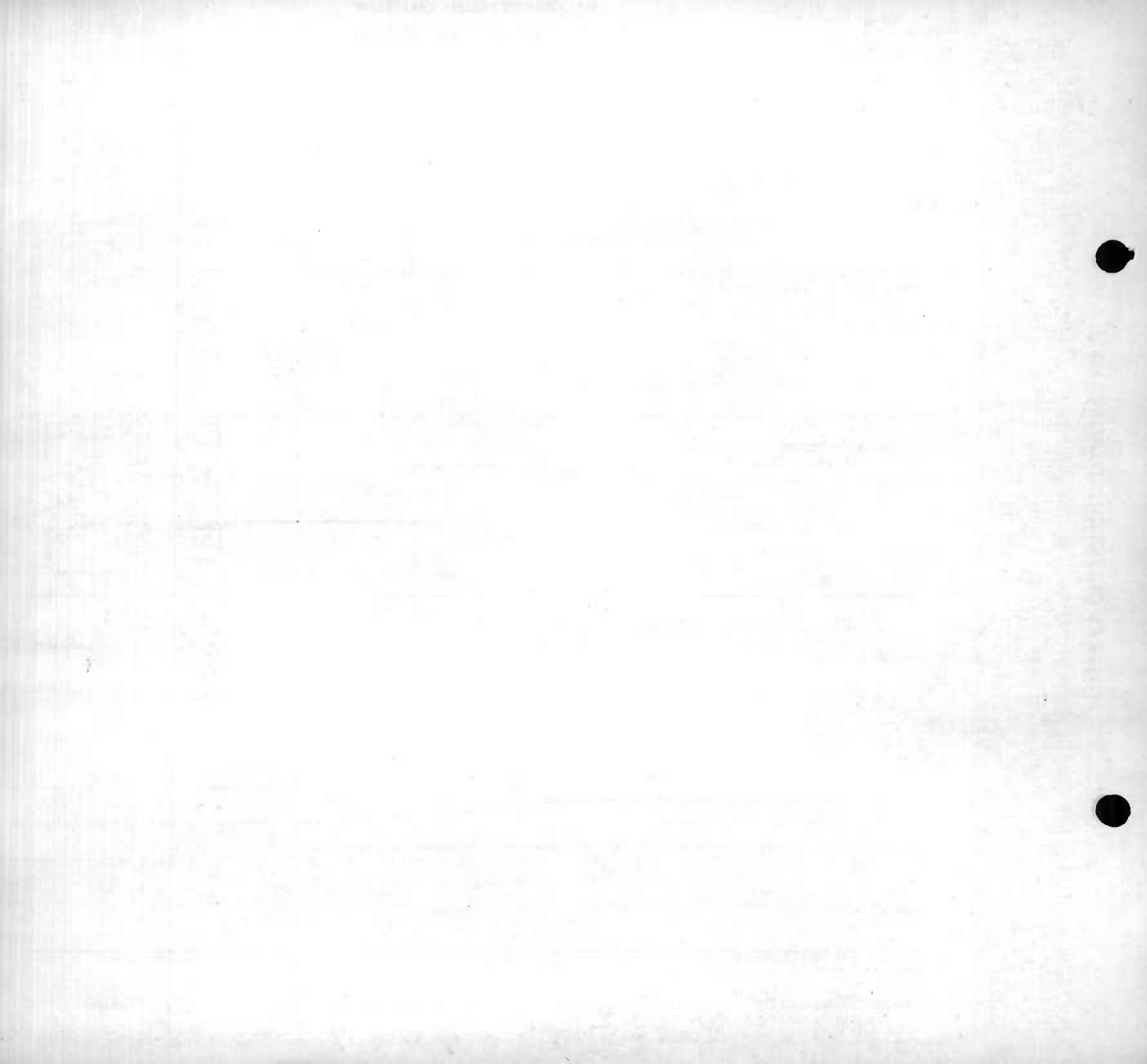


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09963				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09963	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>George Green</u>				2. DATE AND HOUR OF DEATH <u>10-2-66</u> <u>10 20</u> <u>A</u> <u>M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 University Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>16-03</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>908 N. Gilmer St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Not Known</u>	8. DATE OF BIRTH <u>11/30/72</u>	9. AGE (In years last birthday) <u>94</u> <u>93</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not Known</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Not Known</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Not Known</u>				
14. MOTHER'S MAIDEN NAME <u>Not Known</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>Not Known</u>			17. INFORMANT <u>Ellouise Harrison</u> ADDRESS <u>908 Gilmer Street</u>				
18. <u>446X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <u>UREMIA.</u> (A) DUE TO <u>ARTERIOULAR NEPHROSCLEROSIS</u> (B) DUE TO <u>—</u> (C) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>YEARS</u> <u>15-16</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ELECTROLYTE IMBALANCE</u> <u>DEHYDRATION.</u> <u>Prostatic Hypertrophy</u>							
19A. DATE OF OPERATION <u>0 N/A</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> <u>N/A</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>9-27-66</u> <u>19</u> to <u>10-2</u> <u>19</u> <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-2</u> <u>19</u> <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ralph M. Howard</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>10-2-66</u>			
23C. PHYSICIAN'S NAME (Type) <u>Ralph M. Howard</u>				23D. ADDRESS <u>University Hospital</u> <u>Balto, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-6-66</u>		24C. NAME of CEMETERY or CREMATORY <u>New Catheral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1966</u>		25B. NAME OF REGISTRAR <u>Ralph E. Faldema</u>		25C. FUNERAL DIRECTOR <u>George G. Kelson</u>		ADDRESS <u>1348 N. Calhoun St.</u>	

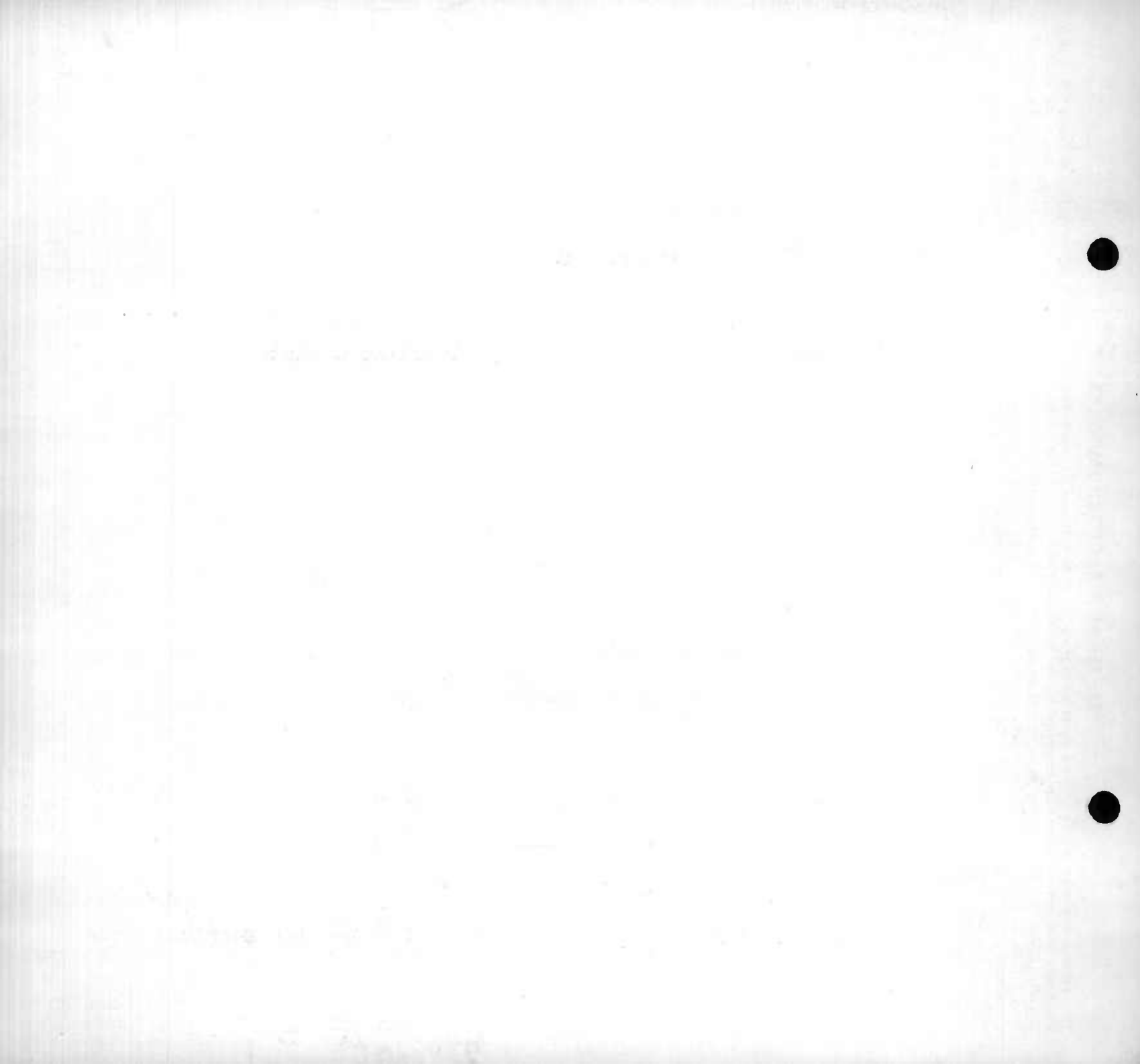




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 09964					CERTIFICATE OF DEATH					Registered No. 66 09964									
1. NAME OF DECEASED (Type or Print) <u>Martins Boyd</u>										2. DATE AND HOUR OF DEATH <u>10/2/66</u> <u>10:15</u> M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____									
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> <u>The Johns Hopkins Hospital</u> (If not in hospital or institution, give street address or location)										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>									
										D. STREET ADDRESS (If rural, give location) <u>4021 Cranson Avenue</u> <u>BRANSTON</u>									
5. SEX <u>F</u>		6. RACE <u>N.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>06-16-90</u>		9. AGE (In years last birthday) <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Robert Jones</u>										14. MOTHER'S MAIDEN NAME <u>Caroline Christie</u>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS <u>Carolyn Murray 411 Seagull Avenue</u>									
18. <u>450.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Apnea</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>Cerebral atherosclerotic disease</u>										CAUSE OF DEATH (A) DUE TO _____ (B) DUE TO _____ (C) DUE TO _____					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <u>Yes</u>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that <del>(if)</del> (this hospital) attended the deceased from <u>9/19</u> 19 <u>66</u> to <u>10/2</u> 19 <u>66</u> , that <del>(we)</del> (we) lost saw the deceased alive on <u>10/2</u> 19 <u>66</u> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(I)</del> (We) (did) <del>(did not)</del> view the body after death.																			
23A. SIGNATURE <u>Murray A. Katz</u> M.D.										23B. DATE SIGNED <u>10/3/66</u>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				
23C. PHYSICIAN'S NAME (Type) <u>Murray A. Katz</u>										23D. ADDRESS <u>The Johns Hopkins Hospital</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>10-6-66</u>					24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>					24D. LOCATION (City, town, or county) (State) <u>Arbutus Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1966</u>					25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>					25C. FUNERAL DIRECTOR <u>George Kelson</u>					ADDRESS <u>1348 N. Calhoun Street</u>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09965				BALTIMORE CITY HEALTH DEPARTMENT		86 09965	
M.E. CASE NO.				CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <i>Crawford, Louise</i>				2. DATE AND HOUR OF DEATH <i>OCT 1 - 1966</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>19-02</i>	
36 <i>Franklin Square Hospital</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
D. STREET ADDRESS (If rural, give location) <i>1807 W. Fayette St.</i>							
5. SEX <i>F</i>	6. RACE <i>C.</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>Aug. 10 1910</i>	9. AGE (In years last birthday) <i>56</i>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Loney Rollin</i>				14. MOTHER'S MAIDEN NAME <i>Unknown Lillie</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital chart.</i>		ADDRESS	
18. <i>410X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO <i>Acute pulmonary edema</i> (B) DUE TO <i>complicating severe</i> (C) <i>tr R.H.D.</i>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>Sept. 30 1966</i> to <i>Oct. 1 1966</i> , that (I) <i>(we)</i> lost saw the deceased alive on <i>Oct. 1 1966</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> <i>(did)</i> (did not) view the body after death.							
23A. SIGNATURE <i>H. B. Lee</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Oct. 1. 1966.</i>	
23C. PHYSICIAN'S NAME (Type) <i>Ki Buun Wee</i>				23D. ADDRESS <i>Franklin Square Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>10-4-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>ZION CHURCH</i>		24D. LOCATION (City, town, or county) (State) <i>CATARA S.C.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 4 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>James H. Hays</i>		ADDRESS <i>138 N. Gilmor St.</i>	

NOT 1-1950

Midon

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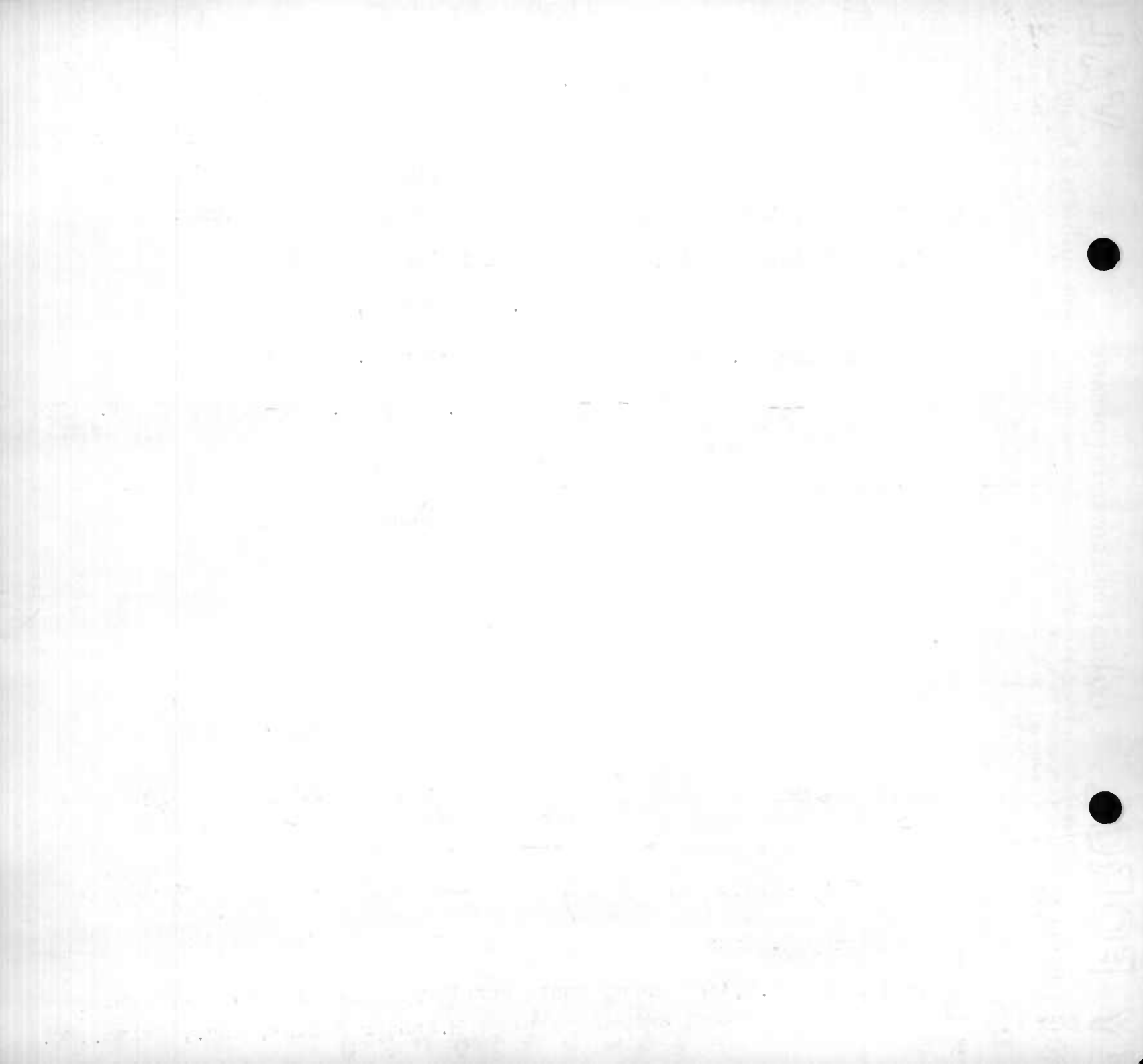
Grant of primary school  
reconstruction of school  
for the school  
L. R. H. D.

Memorandum to Zion Church, Canton 12.2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 09966</b>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b>		Registered No. <b>66 09966</b>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>Henry McCall (HENRY H. McCALL)</b>			2. DATE AND HOUR OF DEATH <b>9/30/66 12:50 pm</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Johns Hopkins Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>7-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>509 North Curley Street</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>1/29/06</b>	9. AGE (In years lost birthday) <b>60</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxi Cab Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Yellow Cab Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Charles N. McCall</b>		
14. MOTHER'S MAIDEN NAME <b>Mary W. Hewitt</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>219-01-4017</b>			17. INFORMANT ADDRESS <b>Mrs. Evelyn W. Betz-8002 Bank St. 21224</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Pulmonary Disease</b>			CAUSE OF DEATH (A) <b>Respiratory Failure</b> DUE TO (B) <b>Chronic Pulmonary Disease</b> DUE TO (C) _____		
INTERVAL BETWEEN ONSET AND DEATH			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Probable Carcinoma of Lung</b>		
19A. DATE OF OPERATION <b>9/23</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Yes</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>this</b> (this hospital) attended the deceased from <b>9/23</b> 19 <b>66</b> to <b>9/30</b> 19 <b>66</b> , that <b>we</b> last saw the deceased alive on <b>9/30</b> 19 <b>66</b> and that in <b>our</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>We</b> (We) (did not) view the body after death.					
23A. SIGNATURE <b>Murray A. Katz</b>				23B. DATE SIGNED <b>9/30/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Murray A. Katz</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>Oct. 3, '66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenmount Crematory</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H. Sander &amp; Sons, Inc., Balto., Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09967		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09967	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>GEORGE HENRY BROWNING</b>			2. DATE AND HOUR OF DEATH <b>October 2, 1966   7.00 P. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Long Green Nursing Home 115 E. Melrose Ave.</b>			A. STATE <b>Maryland</b> B. COUNTY <b>2402</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21230</b>		
90			D. STREET ADDRESS (If rural, give location) <b>1159 Riverside Avenue</b>		
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify) married</b>	8. DATE OF BIRTH <b>Jan. 20. 1880</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>George H. Browning</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Frances Stone</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Charlotte Browning (Wife) 1159 Riverside Ave. Baltimore 21230</b>
18. <b>442X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>Congestive Heart Failure</b> DUE TO (B) <b>Arterio Sclerotic C.R.V. Disease</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b> <b>Many years</b>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>Oct 7</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Oct 7</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <b>yes</b>					
23A. SIGNATURE <b>George McLean</b>				23B. DATE SIGNED <b>Oct. 4, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>George McLean</b>				23D. ADDRESS M.D. <b>Medical Arts Bldg.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 5. 1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION <b>Baltimore Md.</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>		25C. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC.</b>	
				ADDRESS <b>Baltimore Md.</b>	

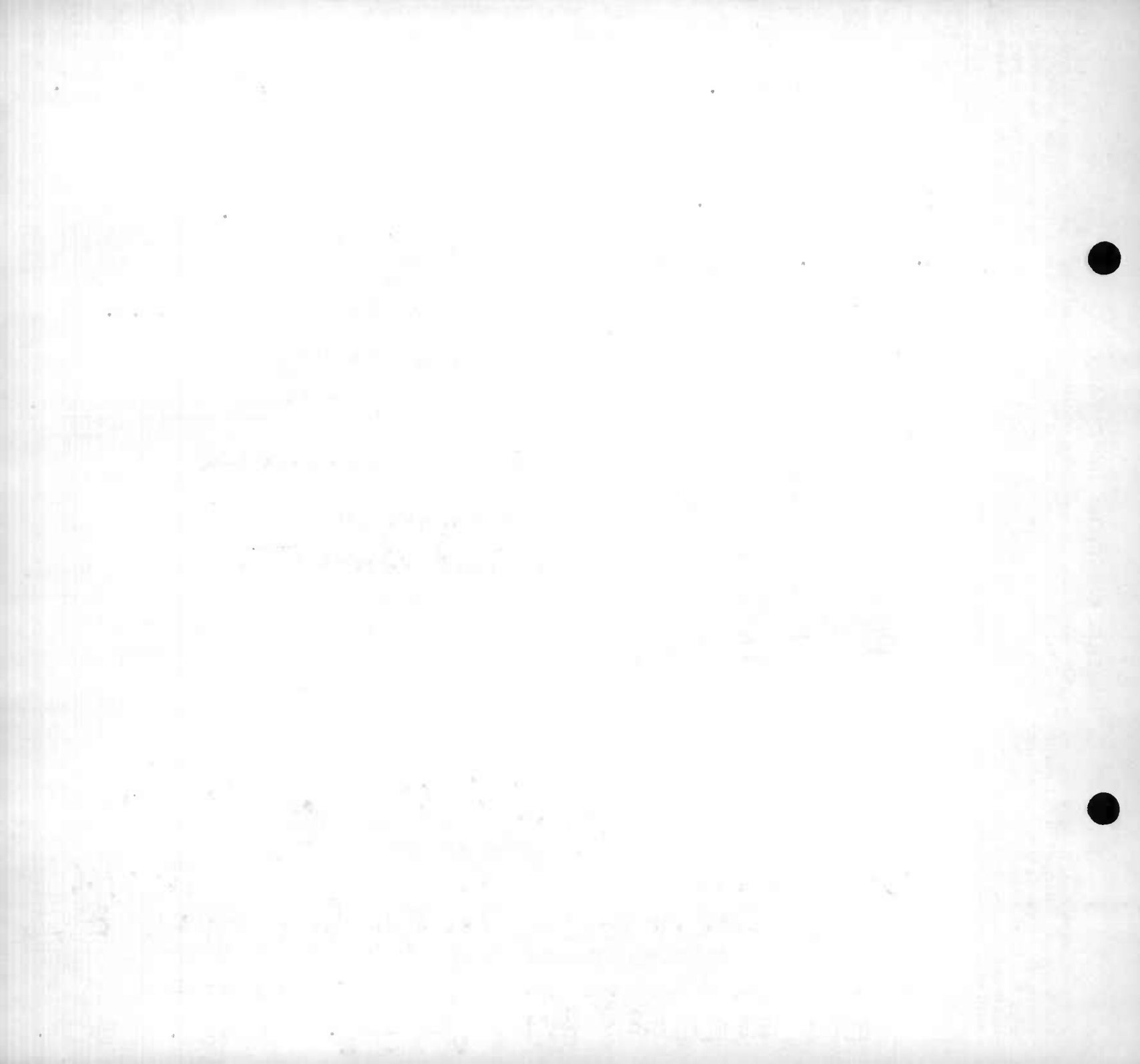




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

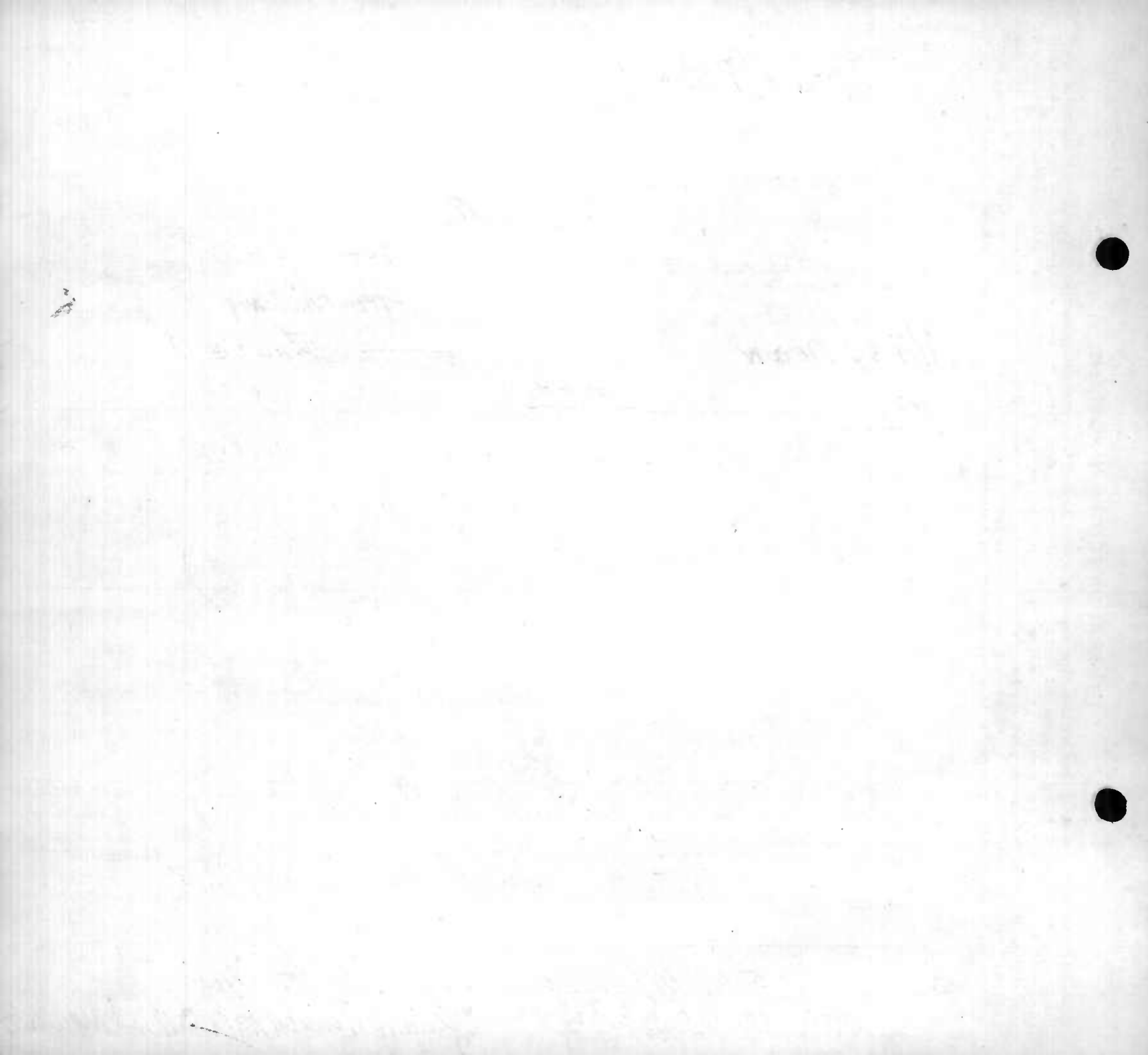
BIRTH NO. 66 09968		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 09968	
1. NAME OF DECEASED (Type or Print) <b>Oscar F. Ringgold</b>			2. DATE AND HOUR OF DEATH <b>October 1, 1966 10:00 P. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> <b>2918 Ridgewood Ave.</b> (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-13</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2918 Ridgewood Ave.</b>		
5. SEX <b>M.</b>	6. RACE <b>C.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1/2/98</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Samuel Ringgold</b>			14. MOTHER'S MAIDEN NAME <b>Georgia Carter</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Lillian Ringgold 2918 Ridgewood Ave.</b> ADDRESS		
18. <b>3-02-01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH <b>Lobar Pneumonia</b> (A) DUE TO <b>Emphysema</b> (B) DUE TO <b>Chronic Bronchitis</b> (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/1/66 11/8/59</b> 19 to <b>10/1/66</b> 19 that (I) (we) last saw the deceased alive on <b>10/1/66</b> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. Garner</b>			23B. DATE SIGNED <b>10/3/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>W. GARNER</b>			23D. ADDRESS <b>1005 W. Lafayette Ave</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/5/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION <b>Arbutus, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>			
24F. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		24G. FUNERAL DIRECTOR <b>Charles A. Rice</b>			
24H. ADDRESS <b>661 W. Barre St.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 09969</b>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b>		Registered No. <b>66 09969</b>	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>Brown, Pattie</b>		
2. DATE AND HOUR OF DEATH <b>Oct. 1, 1966 8<sup>30</sup> A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>20-01</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>36 Franklin Square Hospital</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>1906 Penrose Ave.</b>		
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>Jan. 7, 1904</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>N. C. - Franklinton</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Alfred Dean</b>			14. MOTHER'S MAIDEN NAME <b>Unknown Grace ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Hospital chart</b> ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		
<p style="text-align: center;"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 19 1966</b> to <b>Oct. 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>Oct. 1, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>K. B. Lee</b> M.D.				23B. DATE SIGNED <b>Oct. 1, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ki Bum Lee</b>			23D. ADDRESS <b>Franklin Square Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/5/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>McAuburn Cem. Balto. Md.</b>	
24D. LOCATION (City, town or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Williams Funeral Home 317 N. Schroeder St.</b>		ADDRESS			



5.315

CERTIFICATE OF DEATH

Registered No. 66 09970

BIRTH NO. 66 09970		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <i>James Wm Stepney</i>		2. DATE AND HOUR OF DEATH 9-30-66 1:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 821 N. Calhoun St 00		A. STATE <i>md</i> B. COUNTY <i>16-02</i>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
		D. STREET ADDRESS (If rural, give location) <i>821 N. Calhoun St</i>	
5. SEX <i>Male</i>	6. RACE <i>Col</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH 9-15-1878
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 88
11. BIRTHPLACE (State or foreign country) <i>Broadneck Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Stepney</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>218-09-566</i>	
17. INFORMANT <i>James Stepney</i>		ADDRESS <i>1112 N. Gilman St</i>	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Arteriosclerotic Cardio-vascular disease</i> (B) <i>Myocardial infarction</i> (C)	
INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>September 26, 1966</i> to <i>19</i> , that (I) <del>was</del> last saw the deceased alive on <i>September 26, 1966</i> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <del>did</del> (did not) view the body after death.			
23A. SIGNATURE <i>Royston B. Scott</i> M.D.		23B. DATE SIGNED <i>Oct 1, 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>ROYSTON B. SCOTT</i> M.D.		23D. ADDRESS <i>1801 W. Baltimore St Baltimore, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10-3-66</i>	24C. NAME of CEMETERY or CREMATORY <i>Arbutus Mem. PK.</i>	24D. LOCATION (City, town, or county) (State) <i>Arbutus Md</i>
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 4 1966</i>	25B. NAME OF REGISTRAR <i>Robert E. Farley</i>	25C. FUNERAL DIRECTOR <i>Therese P. Aden - Balto. Md.</i>	
ADDRESS			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Medical Examiner Officially called as re  
FUNERAL DIRECTOR: IMPORTANT

1031

10-25-19

8

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09971				CITY OF BALTIMORE HEALTH DEPARTMENT		Registered No. 66 09971	
1. NAME OF DECEASED (Type or Print) <b>LYNCH, CHESTER</b>				2. DATE AND HOUR OF DEATH <b>9/24/66 7:35 PM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Lutheran Hospital of Maryland Baltimore, Md. 21216</b> <b>46</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-02</b>			
5. SEX <b>Male</b>				6. RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>3/31/17</b>		9. AGE in years (last birthday) <b>49</b>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. UNDER 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Nat Lynch</b>			
14. MOTHER'S MAIDEN NAME <b>Catherine Lynch</b>				15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)			
16. SOCIAL SECURITY NO. <b>237-21-5079</b>				17. INFORMANT <b>Lizella Lynch - Nash Co. N.C.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>September 24 1966 2:30 PM</b> to <b>September 24 1966 7:30 PM</b>		that (I) (we) last saw the deceased alive on <b>September 24 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>Manuel G. Fontanilla</b> M.D.				23B. DATE SIGNED <b>9/24/66</b>		23C. PHYSICIAN'S NAME (Type) <b>Manuel G. Fontanilla</b> M.D.	
23D. ADDRESS <b>Lutheran Hospital of Maryland Baltimore, Md. 21216</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>9-28-66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove</b>		24D. LOCATION (City, town, or county) (State) <b>Halifax Co., N.C.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>	
25B. NAME OF REGISTRAR <b>Robert E. Fisk</b>		25C. FUNERAL DIRECTOR <b>Gurnell S. Aden - Salts, Md.</b>		25D. ADDRESS		25E. ADDRESS	



Not Lysed

Catharine Lysed

207-24501 Lyell Lysed - 100% to 100%

Small 9-1000 Lyell Lysed - 100% to 100%

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 09972	
BIRTH NO. 66 09972				Registered No. 66 09972	
M.E. CASE NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Thomas Graves</b>				2. DATE AND HOUR OF DEATH <b>9-27-66 11:45 p.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital 1514 Division Street Baltimore, Maryland 21217</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1602</b>	
5. SEX <b>Male</b>				6. RACE <b>Negro</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>				8. DATE OF BIRTH <b>6-17-1919</b>	
9. AGE (In years last birthday) <b>47 yrs.</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Graves</b>				14. MOTHER'S MAIDEN NAME <b>Susie Dare</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Morris Comegys (Friend)</b>				ADDRESS <b>Same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>581.0 I</b>				CAUSE OF DEATH (A) <b>Cirrhosis of Liver</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO	
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>September 11, 1966</b> to <b>September 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>September 27, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Laredo</b>				23B. DATE SIGNED <b>9-30-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. C.I. Laredo</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-3-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. (State) <b>md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>	
25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>James G. Oden</b>		ADDRESS <b>Balto, Md.</b>	

1000 N. 1st Street  
St. Paul, Minn.

St. Paul, Minn.  
Sept. 17, 1916

My dear Sir:

Dear Sir:

Enclosed for you are

two copies of

copy of the report

Dr. C. I. Brown

66 09973

BALTIMORE CITY HEALTH DEPARTMENT

66 09973

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES L. BERNARD

2. DATE AND HOUR PRONOUNCED DEAD

September 27, 1966 6:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1309 Madison Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

1893

9. AGE (In years  
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Atlanta, Georgia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

25-07-6213

17. INFORMANT

ADDRESS

Cecilia Delphman 1309 Madison Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/27/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Oct. 1, 1966

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery Brooklyn

23D. LOCATION

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 4 1966

24B. NAME OF REGISTRAR

Rudiger E. Fahrenholz

24C. FUNERAL DIRECTOR

Joseph L. Kuss

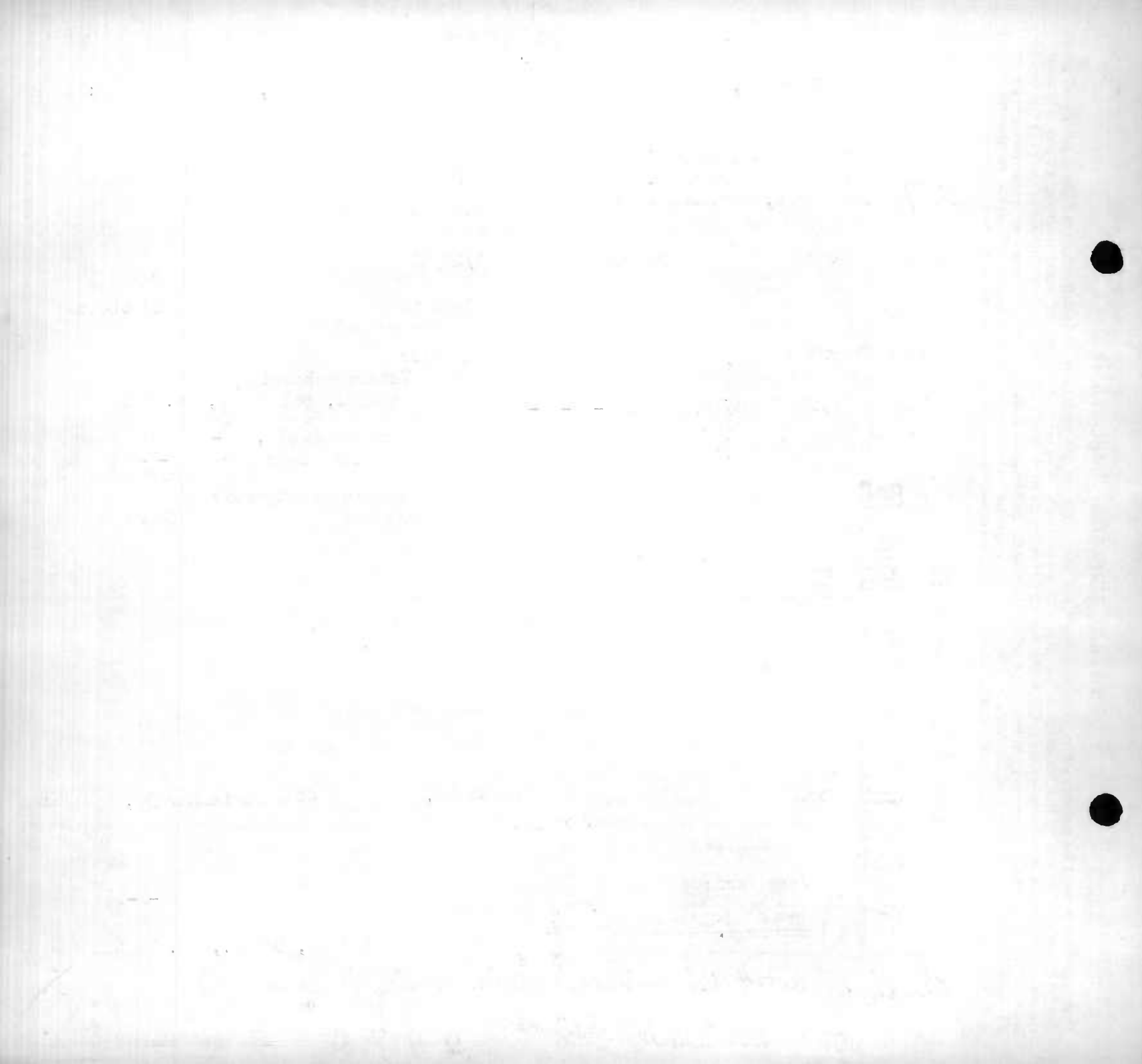
ADDRESS

2222 N. North An.  
Baltimore Md.

WALTER  
B. B. B. B.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 09974	
BIRTH NO. 66 09974		<b>CERTIFICATE OF DEATH</b>		2. DATE AND HOUR OF DEATH September 30, 1966 8:15 PM.	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Thornton, Edward Herman					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1101 Bentlout St			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/27/92	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Joseph Thornton		12. CITIZEN OF WHAT COUNTRY? United States			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10/27/17 to 4/10/18		16. SOCIAL SECURITY NO. 215-16-79-69		17. INFORMANT Veterans Hospital Records, Baltimore, Md. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  Pulmonary emboli, bi- with infarctions of both lower lobes DUE TO Emphysema bullous obstructive severe bilateral		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 6-7 days and 30 minutes	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Pulmonary tuberculosis, arrested both apices		Years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from August 26, 19 66 to September 30, 19 66, that (X) (we) lost saw the deceased alive on September 30, 1966 66 and that in (X) (y) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose Ramirez M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 10-1-66	
23C. PHYSICIAN'S NAME (Type) Jose Ramirez - R. M.D. Robert R. Brawley				23D. ADDRESS Veterans Hospital, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct 4, 1966		24C. NAME OF CEMETERY OR CREMATORY Antioch Bapt. Ch. Cemetery, Middlebury Ct.	
24D. LOCATION Va.		24E. DATE REC'D BY HEALTH DEPT.			
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1966		25B. NAME OF REGISTRAR Robert E. Farkema		25C. FUNERAL DIRECTOR Joseph L. Glusa 2222 W. North Ave	



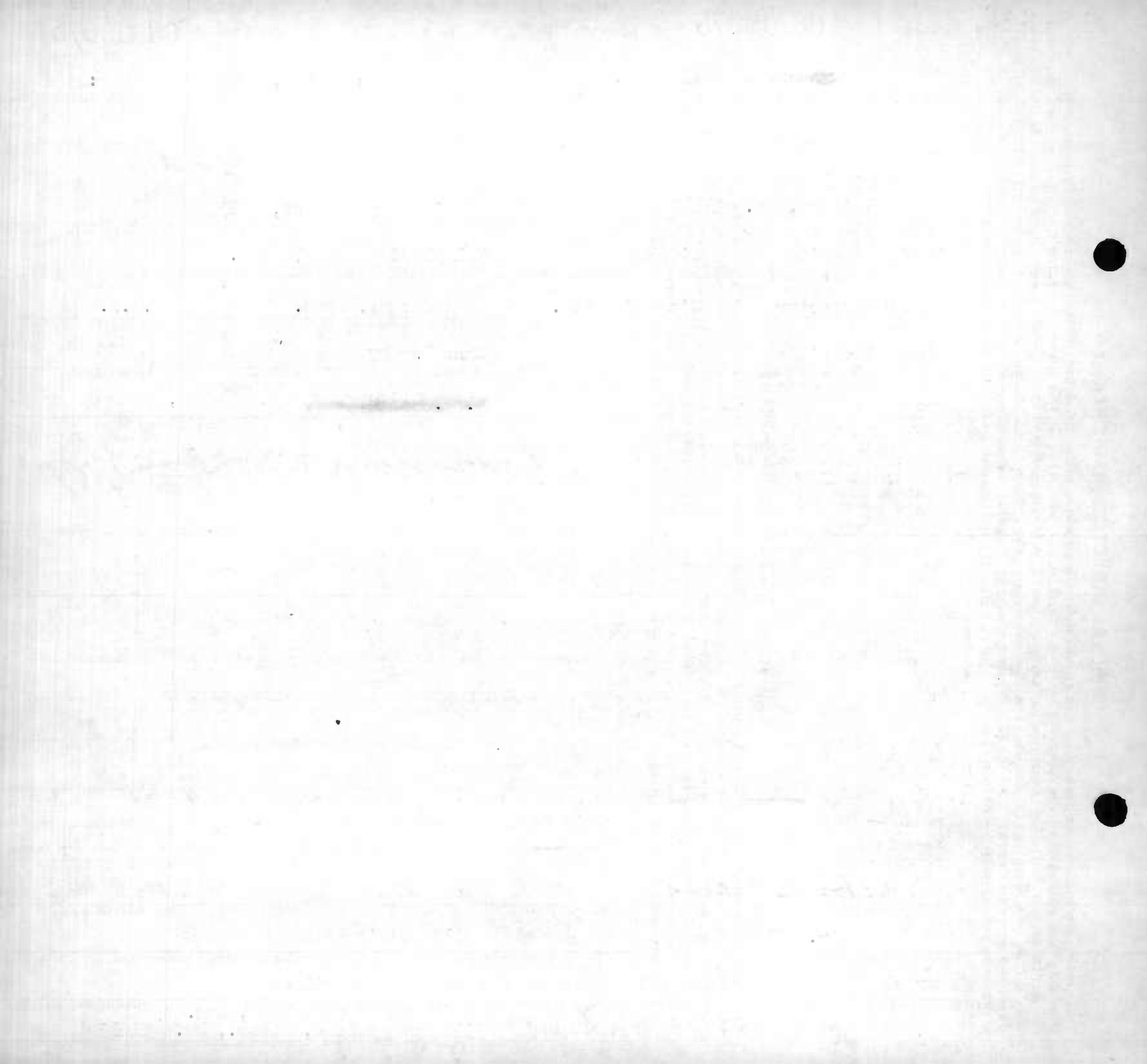


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 09975		CERTIFICATE OF DEATH				Registered No. 66 09975			
1. NAME OF DECEASED (Type or Print) <b>ENDREŞ, NELLIE ELLEN</b>					2. DATE AND HOUR OF DEATH <b>October 2, 1966</b> 8:45 a. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>00 3223 Elmora Avenue Baltimore, Md. 21213</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3223 Elmora Avenue, #13</b>				
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>7/16/1890</b>	9. AGE (In years last birthday) <b>76 yrs.</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Water Inspector</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>City of Balto.</b>		11. BIRTHPLACE (State or foreign country) <b>Hokendauqua, Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Leake</b>			14. MOTHER'S MAIDEN NAME <b>Anna Murphy</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Miss. Ellen Murphy, cousin, above</b>				
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <b>Hypertensive C.V Disease</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>27 years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1-6-1939</b> to <b>9-30-1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>9-30-1966</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>Milton C. Lang</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10-3-66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. Milton Lang</b>			23D. ADDRESS M.D. <b>2117 Belair Road</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-6-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL HOME <b>Schmittke Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane, Balto., Md. 21213</b>			

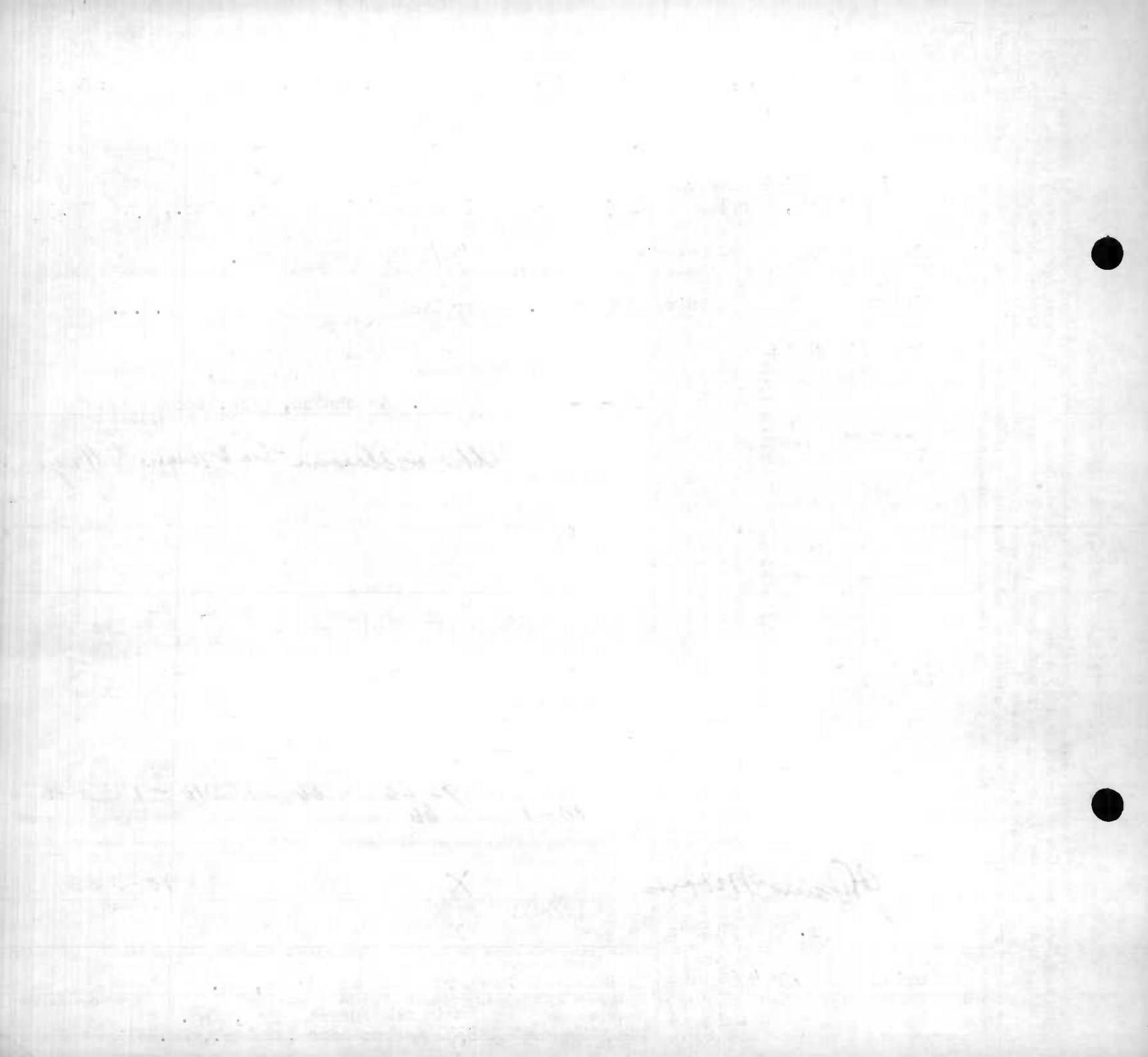




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">66 09976</span>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="float: right;">66 09976</span>	
1. NAME OF DECEASED (Type or Print) <b>KIRSCHNICK, RUDOLPH FRANCIS</b>				2. DATE AND HOUR OF DEATH <b>October 1, 1966 6:45 a. m.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3026 Mayfield Avenue Baltimore, Maryland 21213</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3026 Mayfield Avenue, Balto., Md. 21213</b>			
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>9/30/1882</b>	9. AGE (In years lost birthday) <b>84 yrs.</b>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>University of Md.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herman Kirschnick</b>				14. MOTHER'S MAIDEN NAME <b>Mary Williams</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-20-7898</b>		17. INFORMANT ADDRESS <b>Mary E. Kirschnick, wife, above</b>			
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>atherosclerosis heart disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>1/2 yr.</b>				(A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>9-26-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>20</b>		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9-26-66</b> to <b>10-1-66</b> , that (I) (we) last saw the deceased alive on <b>10-1-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Dr. Duer Moores</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10-3-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Duer Moores</b>		23D. ADDRESS <b>3105 Belair Road</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/4/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane, Balto., Md. #13</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09977		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 09977	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) GROOMS, BERTHA E.		
2. DATE AND HOUR OF DEATH October 2, 1966 10:55 a.m.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 4006 Elmora Avenue Baltimore, Maryland 21213			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-03 D. STREET ADDRESS (If rural, give location) 4006 Elmora Avenue, Balto., Md. #13		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 3/23/1888	9. AGE (In years last birthday) 78 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Samuel P. Norris		
14. MOTHER'S MAIDEN NAME Eldora Roby			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 215-03-1694			17. INFORMANT ADDRESS B Joanna E. McKee, dght., above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I 199.2 CAUSE OF DEATH (A) <u>Carcinomatous abdominal</u> DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <u>approx 8 m</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Arteriosclerosis CVD</u>			5yr		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>17 July</u> <u>1946</u> to <u>2 Oct</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>1 Oct</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Howard Goodman</u>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3 Oct 1966</u>
23C. PHYSICIAN'S NAME (Type) Dr. Howard Goodman			23D. ADDRESS M.D. 8604 Harford Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/5/66	24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem.		24D. LOCATION (City, town, or county) (State) Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1966		25B. NAME OF REGISTRAR <u>Robert E. Tolson</u>		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. #13	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09978	
BIRTH NO. 66 09978		CERTIFICATE OF DEATH			
M.E. CASE NO. 66 09978		2. DATE AND HOUR OF DEATH September 30, 1966 8:30 p.m.			
1. NAME OF DECEASED (Type or Print) BELTZ, RUTH EVERS		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 9.9.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Clifton Nursing Home		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 52-00			
		D. STREET ADDRESS (If rural, give location) 4 Margaret Avenue, Glen Bernie, Maryland			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 5/8/1886	9. AGE (In years lost birthday) 80 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10B. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Charleston, West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown Harry Glassford		14. MOTHER'S MAIDEN NAME Unknown Sally Mohler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-05-5383		17. INFORMANT ADDRESS #13 William Beltz Jr., son, 3202 Clarence Ave.	
18. 433.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) HEART BLOCK DUE TO (B) Chronic myocardial degeneration DUE TO (C) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH one day ?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 28, 1965 to Sept. 30, 1966 that (I) (we) lost saw the deceased alive on Sept. 30, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Maurice E. Shamer M.D.				23B. DATE SIGNED 10-3-1966	
23C. PHYSICIAN'S NAME (Type) Dr. Maurice E. Shamer M.D.				23D. ADDRESS 3300 W. North Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/3/66		24C. NAME OF CEMETERY or CREMATORY Lorraine Park	
24D. LOCATION Maryland					
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1966		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane, Baltimore, Md. 21213	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.5em;">66 09979</span>	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <span style="font-size: 1.5em;">66 09979</span></p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Elizabeth Loretta Moffett</span></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Sept. 29, 1966</span></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p><span style="font-size: 1.2em;">Gould Convalesarium</span></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Balt. County</span></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span></p> <p>D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">9643 Dixon Ave. 21234</span></p>		
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Widowed</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">March 6, 1888</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">78</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">New York City</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Coleman</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">McGreden</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-52-7629</span>		17. INFORMANT <span style="font-size: 1.2em;">Mr. Leonard Sobon</span>
			ADDRESS <span style="font-size: 1.2em;">9643 Dixon Ave. 21234</span>		
<p>18. <span style="font-size: 1.5em;">173.70 I</span> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><span style="font-size: 1.2em;">(A) Ovarian carcinoma with metastases</span></p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><span style="font-size: 1.2em;">(B) DUE TO</span></p> <p><span style="font-size: 1.2em;">(C) DUE TO</span></p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1. 9 1952</span> to <span style="font-size: 1.2em;">9. 29 1966</span>, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">9. 28 1966</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
23A. SIGNATURE <span style="font-size: 1.2em;">[Signature]</span> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <span style="font-size: 1.2em;">9.30.66</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. Joseph Skloven</span>			23D. ADDRESS <span style="font-size: 1.2em;">7122 Harford Rd.</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">10-3-66</span>	24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Baltimore National Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Catonsville Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 4 1966</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farley</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Wm. Cook-Brooks Towson Inc. 1050 York Rd.</span>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09980				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 09980	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) JAMES WILBURN HUNTER				2. DATE AND HOUR OF DEATH Oct. 4, 1966 12: 25 A M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st St.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ga. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Savannah V-09			
5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married				8. DATE OF BIRTH 9/18/1938		9. AGE (In years last birthday) 28		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ewing Hunter				14. MOTHER'S MAIDEN NAME Louise Kirby					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USA 1965-1958				16. SOCIAL SECURITY NO. 410-64-1695		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.			
18. 204.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) Bronchopneumonia DUE TO				INTERVAL BETWEEN ONSET AND DEATH Days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) Granulocytosis DUE TO				Days	
				(C) acute myelogenous leukemia				Weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from Sept. 21 1966 to Oct. 4 1966, that (X) (we) lost saw the deceased alive on Oct. 4 1966 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. M. Beauchamp M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/4/66			
23C. PHYSICIAN'S NAME (Type) Jon M. Beauchamp, Surgeon (R)				23D. ADDRESS M.D. US PHS Hospital, Balto, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/7/66		24C. NAME of CEMETERY or CREMATORY Bonaventure		24D. LOCATION (City, town, or county) (State) Savannah, Georgia			
25A. DATE REC'D BY HEALTH DEPT. Oct 4 1966				25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St. Baltimore, Maryland			

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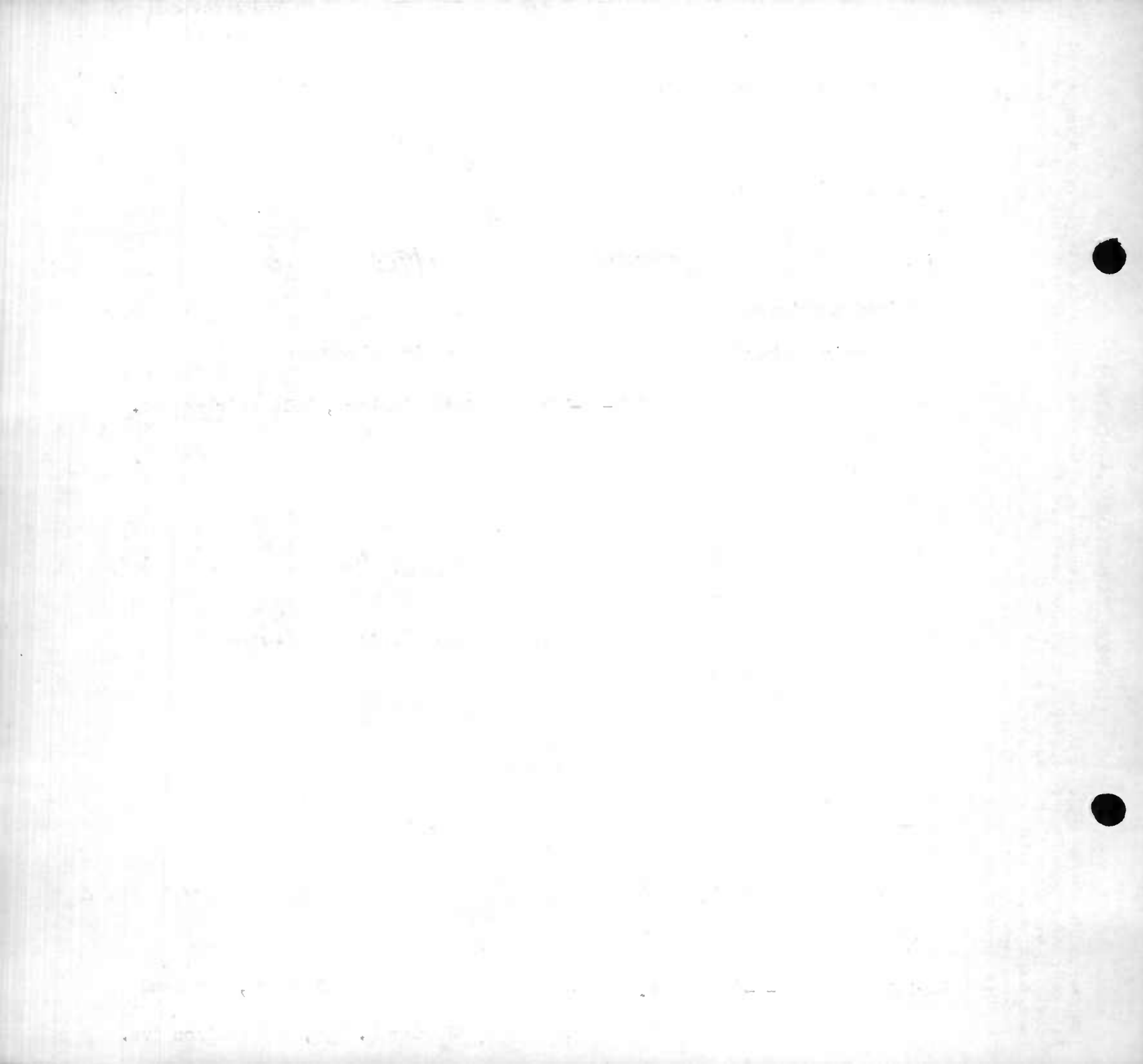
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09981</b>	
BIRTH NO. <b>66 09981</b>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Otha Tankard</b>		2. DATE AND HOUR OF DEATH <b>10-3-66</b> <b>2:00</b> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b> <b>42</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>15-13</b> <b>2510 Shirley Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Separated</b>	8. DATE OF BIRTH <b>9/10/1900</b>	9. AGE (In years last birthday) <b>66</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired machinest</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Louis Tankard</b>		14. MOTHER'S MAIDEN NAME <b>Dellie Brickhouse</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>043-05-7543</b>		17. INFORMANT <b>Rintha Tankard, 2510 Shirley Ave.</b>	
18. <b>5-70.5TY 260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Septic Shock</b> DUE TO (B) <b>Perotinitis</b> DUE TO (C) <b>Intestinal Obstruction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs.</b> <b>16 hrs.</b> <b>2 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Acute Myocardial Infarction Diabetes</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(it)</del> (this hospital) attended the deceased from <b>10/2</b> 19 <b>66</b> to <b>10/3</b> 19 <b>66</b> , that <del>(it)</del> (we) last saw the deceased alive on <b>10/3</b> 19 <b>66</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(We)</del> (We) (did) <del>(not)</del> view the body after death.					
23A. SIGNATURE <b>Allan S. Rudolph</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-3-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Allan S. Rudolph</b>		23D. ADDRESS <b>Sinai Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-6-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>Charles R. Law</b>		25C. FUNERAL DIRECTOR ADDRESS <b>802 Madison Ave.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09982		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09982	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SARAH SHERRILL		2. DATE AND HOUR OF DEATH 10/2/66 7:28 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Maryland General Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BROOKLYN (BALTIMORE AREA) D. STREET ADDRESS (If rural, give location) 629 N. PALM ST			
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8/8/18	9. AGE (In years last birthday) 48	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN GARDNER	
14. MOTHER'S MAIDEN NAME MATTIE TATE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT HUSBAND		ADDRESS SAME			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Septic shock. ACUTE (R) PLEURITIS HEPATIC ABSCESSES TYPE UNDETERMINED		INTERVAL BETWEEN ONSET AND DEATH 1 day 8 days WKS	
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/27/1966 to 10/2/1966, that (I) (we) last saw the deceased alive on 10/2/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John P Doerfer		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/2/66	
23C. PHYSICIAN'S NAME (Type) JOHN P DOERFER		23D. ADDRESS MARYLAND GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-3-66		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. OCT 4 1966			
25B. NAME OF REGISTRAR G. E. Finkbeiner		25C. FUNERAL DIRECTOR The Charles R. Law, 802 Madison Ave			

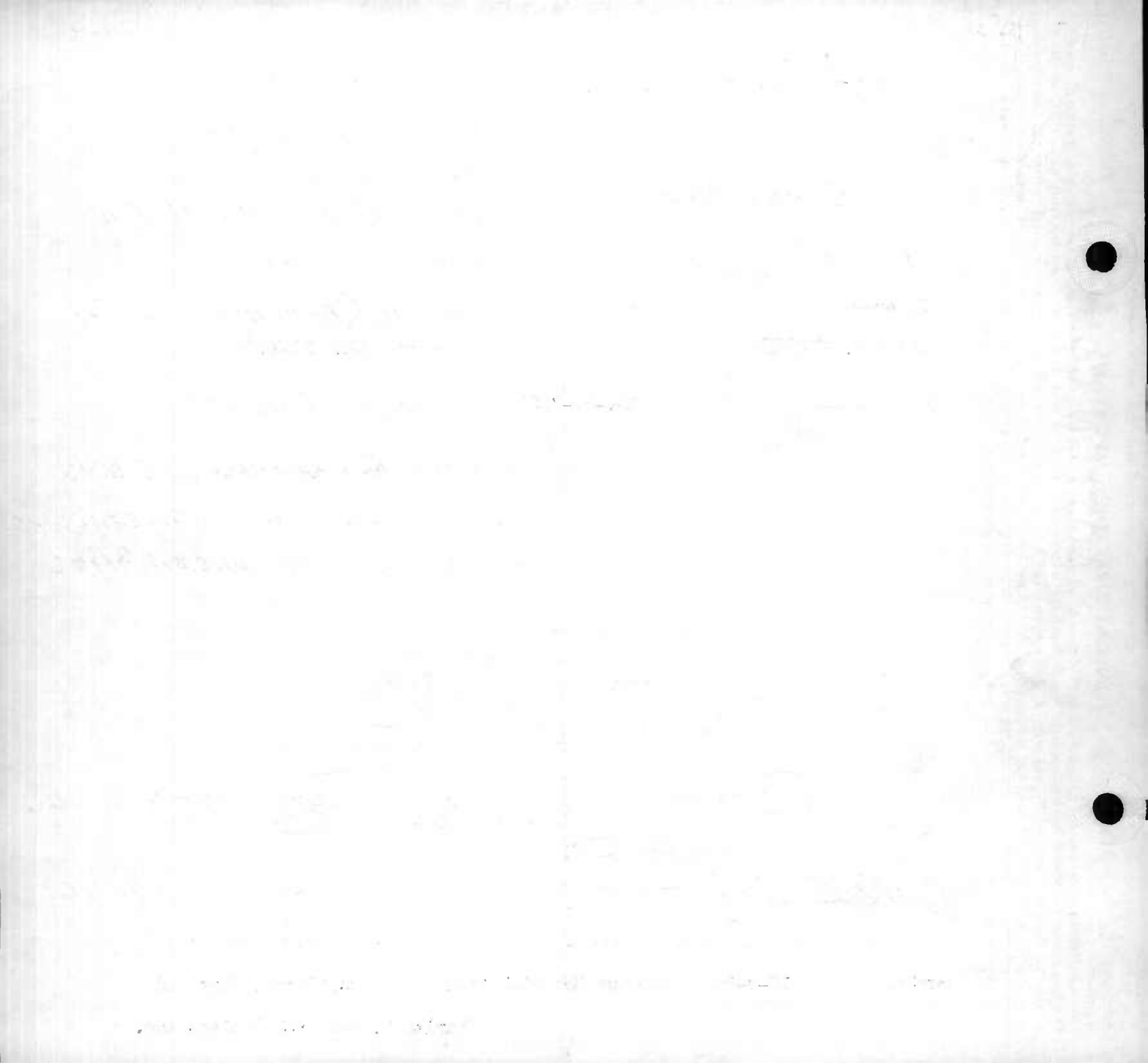
OCT 4 1966 Robert E. Taylor, Jr. 9 9 8 8



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09983				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 09983	
1. NAME OF DECEASED (Type as Print) <b>ROOSEVELT TILLMAN</b>				2. DATE AND HOUR OF DEATH <b>10-4-66 4 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 SINAI HOSP.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>3614 REISTERSTOWN RD.</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>12-25-24</b>	9. AGE (In years last birthday) <b>41</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>GEORGE W. TILLMAN</b>				14. MOTHER'S MAIDEN NAME <b>LENA INGRAM</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>240-20-7504</b>		17. INFORMANT ADDRESS <b>HOSPITAL CHART.</b>		
18. <b>445X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>CEREBRAL HEMORRHAGE</b> DUE TO (B) <b>RENAL FAILURE</b> DUE TO (C) <b>MALIGNANT HYPERTENSION 9 MOS.</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 DAYS</b> <b>SEVERAL WKS.</b>							
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) <b>this hospital</b> attended the deceased from <b>9-18</b> 19 <b>66</b> to <b>10-4</b> 19 <b>66</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>10-3</b> 19 <b>66</b> and that <b>(n)(my)</b> <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. <b>(I)(We)(did)</b> <b>(did nat)</b> view the body after death.							
23A. SIGNATURE <b>Alvin Schachter</b> M.D.				23B. DATE SIGNED <b>10-4-66</b>		23C. PHYSICIAN'S NAME (Type) <b>ALVIN SCHACHTER</b> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-8-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>Charles R. Law</b>		ADDRESS <b>802 Madison Ave.</b>	

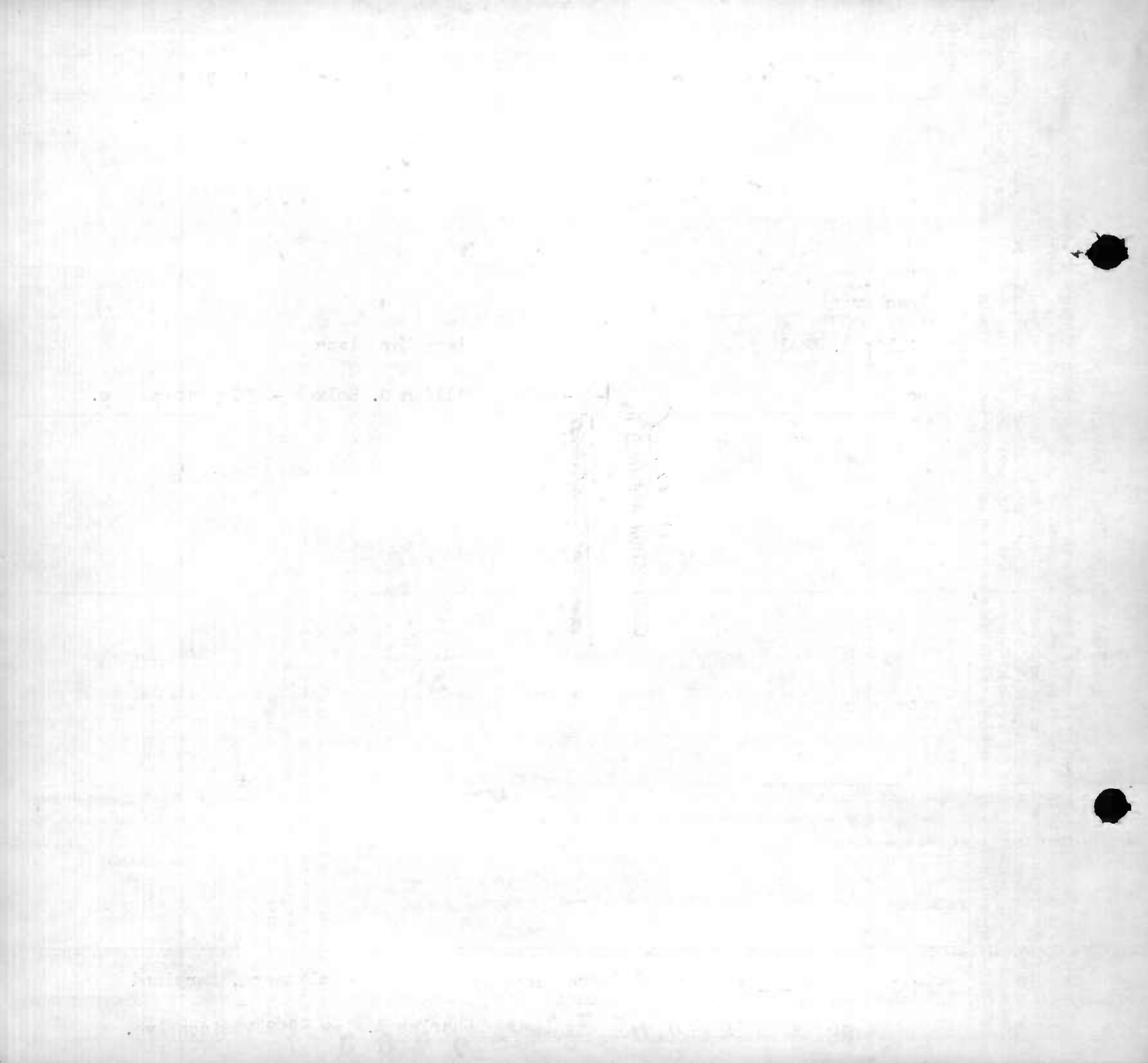




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 09984</u>	
BIRTH NO. <u>66 09984</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Barbara Holmes</u>		2. DATE AND HOUR OF DEATH <u>10/1/66 77 PM</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u> <u>Baltimore</u>		A. STATE <u>MD</u> B. COUNTY <u>BALT</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALT</u>			
		D. STREET ADDRESS (If rural, give location) <u>3916 Wabash Ave</u>			
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>7/12/39</u>	9. AGE (In years last birthday) <u>27</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Willis D. Neal</u>		14. MOTHER'S MAIDEN NAME <u>Lena Mae Dixon</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>239-60-7586</u>		17. INFORMANT ADDRESS <u>William G. Holmes - 3916 Wabash Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Severe Toxicemia (Free clam poia)</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pregnancy</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-29</u> 19 <u>66</u> to <u>10-1</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-1</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Amos Hall</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Amos Hall</u>				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-5-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore National</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Charles R. Law 802 Madison Ave.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09985		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09985	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HELEN M. WEBER		2. DATE AND HOUR OF DEATH Oct. 2, 1966 3:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 00 residence, 3132 Orlando Avenue		D. STREET ADDRESS (If rural, give location) 3132 Orlando Avenue			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Sept. 6, 1913	9. AGE (in years last birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) legal secretary		10B. KIND OF BUSINESS OR INDUSTRY Herbert Wynne Master Chancery Ct, Towson		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Julius Wiedner		14. MOTHER'S MAIDEN NAME Louisa SHETLER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-5995		17. INFORMANT Milton W. Weber 3132 Orlando Ave.	
18. 173701 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH B (A) Adeno Carcinoma Left ovary DUE TO A (B) Metastasis to liver and DUE TO (C) Peritonitis and liver		INTERVAL BETWEEN ONSET AND DEATH 12 Month 6	
19A. DATE OF OPERATION August 1966		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma ovary		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from August 16 1966 to October 2 1966, that (I) (we) last saw the deceased alive on September 28 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Patrick C. Phelan, Jr. M.D. 23B. DATE SIGNED October 3, 1966	
23C. PHYSICIAN'S NAME (Type) Dr. Patrick C. Phelan, Jr. M.D.		23D. ADDRESS 840 Park Ave., Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 10/5/66		24C. NAME OF CEMETERY or CREMATORY Parkwood CEMETERY	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 4 1966		25B. NAME OF REGISTRAR Robert E. Fabela	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - 5305 Harford Road, 11		25D. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09986		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09986	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Charles M. Le Compte				October 4, 1966 3 <sup>30</sup> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital of Baltimore 42		A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5940 Glen Kirk Rd #12			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-29-13	9. AGE (In years last birthday) 53	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10B. KIND OF BUSINESS OR INDUSTRY Nat. Gypsum Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George A. LeCompte		14. MOTHER'S MAIDEN NAME Kattie Knefely			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-8333		17. INFORMANT Mrs. Norma B. LeCompte	
				ADDRESS (Same)	
18. 151 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Hemorrhage + Hepatic failure. DUE TO (B) CA of Stomach. DUE TO (C) Hepatic Metastasis.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 9/30 19 66 to 10/4 19 66, that (I) (we) last saw the deceased alive on 10/4/ 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fritz Abolton		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/4/66	
23C. PHYSICIAN'S NAME (Type) Fritz Abolton		23D. ADDRESS M.D. Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/7/66		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1966		25B. NAME OF REGISTRAR P. E. E. E. E.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 099887</b>		<b>CERTIFICATE OF DEATH</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09987</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Larken W. Singhass</b>				2. DATE AND HOUR OF DEATH <b>10/1/66 7 p.m.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3913 Chatham Ave. Balt. 21207</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21207</b> D. STREET ADDRESS (If rural, give location) <b>3913 Chatham Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>11/23/1908</b>	9. AGE (In years lost birthday) <b>57</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist-chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Transfer Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Singhass</b>			14. MOTHER'S MAIDEN NAME <b>Mary Grant</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes: W.W. II</b>		16. SOCIAL SECURITY NO. <b>216-01-6901</b>		17. INFORMANT. ADDRESS <b>Mrs. Gwendolyn Singhass-3913 Chatham Ave.</b>			
18. <b>144X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Severe arteriosclerotic heart disease 11 yrs</b>				(A) DUE TO <b>Carcinoma and</b> <b>coronary</b>  (B) DUE TO  (C)   INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs. 3 mos.</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6/28</b> 19 <b>63</b> to <b>9/16</b> 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>9/16</b> 19 <b>66</b> and that in (my) ( <del>the</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>the</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Dr. Robert Chambers</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/3/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Robert Chambers</b>				23D. ADDRESS <b>836 Park Avenue Balt. 21201</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/5/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>3801 Frederick Ave. Balt. 29, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Loring Byers-8728 Liberty Rd. Randallstown</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09988				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09988	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				Sadie Epstein		October 2, 1966 12 <sup>50</sup> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE MARYLAND		B. COUNTY 28-41	
LEVINDALE, HEBREW HOME AND INFIRMARY				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 5611 WILVAN AVENUE			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW		8. DATE OF BIRTH 84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA		9. AGE (In years last birthday) 84	
13. FATHER'S NAME ELCHONON SCHERHTER				14. MOTHER'S MAIDEN NAME ROSE BEINSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NO		17. INFORMANT MR. IRVIN EPSTEIN, 6602 CHELWOOD ROAD #9	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Septic gangrene DUE TO (B) peripheral a.s. vascular dis- DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 mo-	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept. 14 1966 to Oct. 2 1966, that (I) (we) last saw the deceased alive on Oct. 2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ruth Willmer				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Oct 2	
23C. PHYSICIAN'S NAME (Type) Ruth Willmer				23D. ADDRESS M.D. LEVINDALE, Hebrew Home			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/3/66		24C. NAME of CEMETERY or CREMATORY BETH ISAAC ADATH ISRAEL		24D. LOCATION	
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR SOL LEVIT			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 09989	
BIRTH NO. 66 09989		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DAVID LAKEIN		2. DATE AND HOUR OF DEATH 10-1-66 1 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MO B. COUNTY 27-15			
FULL NAME OF HOSPITAL OR INSTITUTION H. Sinai Hosp.		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.	
		D. STREET ADDRESS (If rural, give location) 2209 ROGENE DR. APT 101			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 5-13-12	9. AGE (In years lost birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler		10B. KIND OF BUSINESS OR INDUSTRY Self Employed.		11. BIRTHPLACE (State or foreign country) RUSSIA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ISADOR LAKEIN		14. MOTHER'S MAIDEN NAME ANNA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MRS. BESSYE LAKEIN, 2209 ROGENE DRIVE, APT 101	
18. 356.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Due to Amyotrophic Lateral Sclerosis (B) Due to (C)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 19 66 to Oct. 1 19 66, that (I) (we) last saw the deceased alive on Oct. 1 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lawrence Solomon M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 10-1-66	
23C. PHYSICIAN'S NAME (Type) LAWRENCE SOLOMON				23D. ADDRESS SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/3/66		24C. NAME of CEMETERY or CREMATORY BETH TAYLOR	
		24D. LOCATION BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1966		25B. NAME OF REGISTRAR R. B. E. Farber		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN	

DAVID L. WARD

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GALE

2nd Floor

24

2-13-12

W

W

W

Self & Family

Family

Photograph taken between 5th & 6th

Oct 1

22

22

20

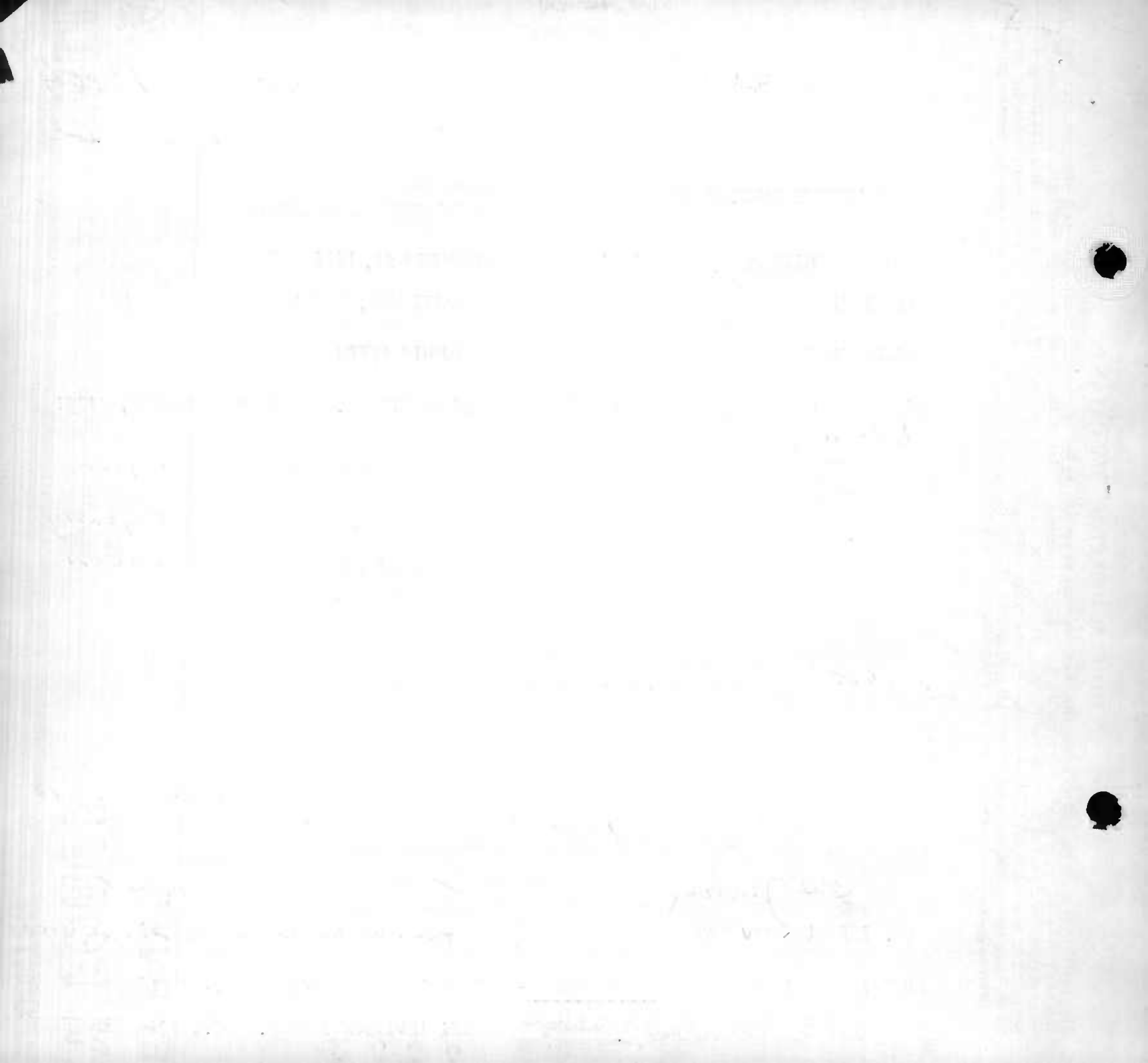
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James Wilson

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>66 09990</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 09990</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<b>CECILIA STERN</b>		<b>OCTOBER 4, 1966 1:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE <b>MARYLAND</b> B. COUNTY		
<b>90 BELVEDERE NURSING HOME</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
D. STREET ADDRESS (If rural, give location) <b>2250 BROOKFIELD AVENUE</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>DECEMBER 25, 1898</b>	9. AGE (In years lost birthday) <b>67</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERICAL</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>MOSES STERN</b>			14. MOTHER'S MAIDEN NAME <b>SOPHIA STERN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT ADDRESS <b>AVRUM RIFMAN, ONE CHARLES CENTER, 21201</b>	
18. <b>170X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Generalized Carcinomatosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>Carcinoma left breast</b> DUE TO <b>5 years</b>		
(C) <b>General arteriosclerosis</b> DUE TO <b>6 years</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0 1965</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ca. left breast</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work At While <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 29th 1966</b> to <b>10/4</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>10/4/66</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Isaiah Zimberg</b>				23B. DATE SIGNED <b>10/4/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. ISRAEL ZIMBERG</b>		23D. ADDRESS <b>4000 W. Northern Parkway (15)</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/5/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>ANSHE EMUNAH-AITZ CHAIM</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 09991				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09991	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>SOL LURIE</b>				2. DATE AND HOUR OF DEATH <b>10-3-66 8:53 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL OF BALTO</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>15-12</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b> D. STREET ADDRESS (If rural, give location) <b>3649 Cottage Ave. #15</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>XXXXXXXXXX</b>	9. AGE (In years lost birthday) <b>57</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MUSICIAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MUSIC</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JACOB LURIE</b>				14. MOTHER'S MAIDEN NAME <b>RACHAEL ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>WW 11 ARMY</b>		16. SOCIAL SECURITY NO. <b>215-10-9849</b>		17. INFORMANT <b>MRS. HILDA LURIE, 3649 COTTAGE AVENUE</b>			
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Ante Myocardial Infarction - flow</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 3, 1966</b> to <b>Oct. 3, 1966</b> , that (I) (we) last saw the deceased alive on <b>Oct. 3, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Gerardo M. Yip Jr.</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9/3/66</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>SINAI HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/4/66</b>		24C. NAME of CEMETERY or CREMATORY <b>AITZ CHAIN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbot</b>		25C. FUNERAL DIRECTOR <b>DSOD LEVINSON &amp; BROS. INC.</b>		ADDRESS <b>6010 REISTERSTOWN</b>	

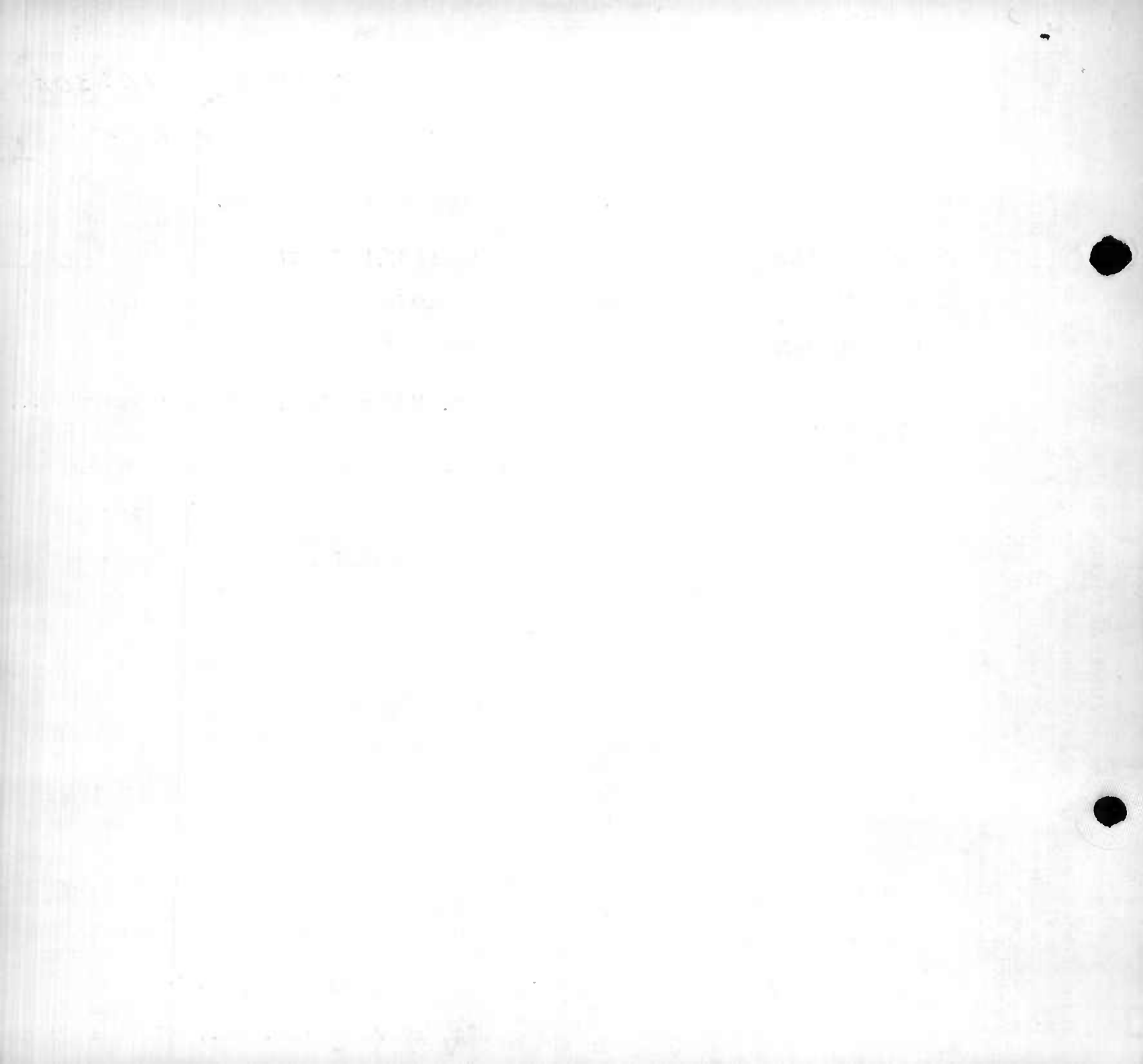




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 09992</b>	
BIRTH NO. <b>66 09992</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>TILLIE NILVA</b>		2. DATE AND HOUR OF DEATH <b>10/3/66 10:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b> B. COUNTY <b>27-20</b>			
<b>00 6302 Cross Country Blvd.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>6302 Cross Country Blvd.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>August 17, 1895</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Louis Oberfeld</b>			
14. MOTHER'S MAIDEN NAME <b>Rena ?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT ADDRESS <b>Mr. Abraham Nilva, 6302 Cross Country Blvd.</b>			
18. <b>260 X I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Cerebral Embolus</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>arteriosclerosis (C.V.D.)</b> DUE TO		<b>5 years</b>	
		(C) <b>Diabetes Mellitus</b>		<b>10 yrs.</b>	
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/1/1966</b> to <b>10/3/1966</b> , that (I) (we) last saw the deceased alive on <b>10/1/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. A. Silver</b>				23B. DATE SIGNED <b>10/3/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>A. A. SILVER</b>		23D. ADDRESS M.D. <b>6210 PARK HEIGHTS, AVE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/5/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Beth Jacob</b>	
24D. LOCATION (City, town, or county) (State) <b>Finksburg, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 09993		REGISTERED NO. 66 09993	
1. NAME OF DECEASED (Type or Print) <b>Cecelia Epstein</b>				2. DATE AND HOUR OF DEATH <b>October 3, 1966 6:10 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 The Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>6809 Brookmill Road</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>2/25/12</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SEREBOFF Hyman</b>				14. MOTHER'S MAIDEN NAME <b>Ida Shait</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-07-1997</b>		17. INFORMATION ADDRESS <b>MR. HARVEY EPSTEIN, 4221 Hickory Avenue</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>22 yrs.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Polyarthritis Kidney Disease</b>				22 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Chronic Pyelonephritis; Post-right nephrectomy</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (if this hospital) attended the deceased from <b>4/6</b> 19 <b>66</b> to <b>10/3</b> 19 <b>66</b> , that (if we) lost saw the deceased alive on <b>10/3</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (if We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>James T. Corkins</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/3/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>James T. Corkins</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/4/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>BETH ISAAC ADAS ISRAEL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>506 LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</b>			



N. 240

66 09994

BALTIMORE CITY HEALTH DEPARTMENT

66 09994

BIRTH NO. Pennsylvania MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

DAWN LISA NAGLE

2. DATE AND HOUR PRONOUNCED DEAD

October 2, 1966

10:22 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)33  
99

John Hopkins Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

724 N. Rose Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

6-2-65

9. AGE (In years  
last birthday)

16 mths.

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wm. G. NAGLE

14. MOTHER'S MAIDEN NAME

BETTY JANE YOUNG

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Betty Jane Nagle - 724 N. Rose St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Interstitial pneumonitis (SDII)  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
(If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 2, 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

10-5-66

23C. NAME of CEMETERY or CREMATORY

MT. OLIVE CEM.

23D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

OCT 5 1966

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Hinterberger - 2334 Jefferson St.

ADDRESS

WALLING  
FIVE  
PAGE

W.M. G. HALL

24th Jan 1941

WALLING



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09995		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 09995	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Mail) Harry Hollis Higgins			2. DATE AND HOUR OF DEATH October 2, 1966 6:15 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Baltimore General Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 25 C. CITY OR TOWN (If outside city limits, write RURAL and give township) 25-04 D. STREET ADDRESS (If rural, give location) 900 Dantry Court		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Jan. 15, 1900	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Chemical	11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unk			14. MOTHER'S MAIDEN NAME Sadie Bell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Susie Higgins (Wife)		ADDRESS as above
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) INTERNAL POSTOPERATIVE DUE TO HEMORRHAGE (B) GASTRIC RESECTION DUE TO (C) BLEEDING DUODENAL ULCER		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from October 1 19 66 to October 2 19 66, that (I) (we) lost saw the deceased alive on October 2 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Consolador C. Palad, Jr.			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED October 2, 1966
23C. PHYSICIAN'S NAME (Type) Consolador C. Palad, Jr.			23D. ADDRESS South Baltimore General Hospital		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/5/66	24C. NAME of CEMETERY or CREMATORY Cedar Hill Cem		24D. LOCATION (City, town, or county) AA Co (State) Md	
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR McCully FH 237 Patapsco Ave 21225	



BRITISH PROBABLY USED  
GASTRIC RESISTION  
HEMLOCK-HAGE  
INTERNAL REPRESENTATIVE

*[Handwritten signature]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 09996					CERTIFICATE OF DEATH		Registered No. 66 09996		
1. NAME OF DECEASED (Type or Print) ALTON CARLYLE STEWART					2. DATE AND HOUR OF DEATH Oct 4, 1966 4:00 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND.					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital					A. STATE MD SEVERN Anne Arundel				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Route 3 Box B - Severn				
					D. STREET ADDRESS (If rural, give location) A. Reese Road				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6/22/09	9. AGE (In years last birthday) 57	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Clerk		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph H. Stewart					14. MOTHER'S MAIDEN NAME Mary Phelps				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 217-77750		17. INFORMANT Mrs. Anita Mays (sister)		ADDRESS Same As #2
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) ARTERIO-SCLEROTIC C.V.D. DUE TO (B) ACUTE MYOCARDIAL Infarction DUE TO (C) CARDIO-GENIC Tachycardia				INTERVAL BETWEEN ONSET AND DEATH 3 hr 12 min
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept 23 1966 to Oct 4 1966, that (I) (we) last saw the deceased alive on Oct 4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Dr. Ann Robinson					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED Oct 4, 1966	
23C. PHYSICIAN'S NAME (Type) Dr. Ann Robinson					23D. ADDRESS Univ Hosp				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE Oct-7-66			24C. NAME OF CEMETERY or CREMATORY Friendship Cemetery			24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Maryland
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1966			25B. NAME OF REGISTRAR R. E. Taylor			25C. FUNERAL DIRECTOR R. E. Taylor			ADDRESS Singleton Funeral Home Glen Burnie, Md.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 09997				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 32-71-46	
M.E. CASE NO.				66 09997			
1. NAME OF DECEASED (Type or Print) GROVE, RICHARD, William				2. DATE AND HOUR OF DEATH 10/2/66 8:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 28-04	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE-29				D. STREET ADDRESS (If rural, give location) 206 Mallow Hill Road.			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/24/01	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Service		10B. KIND OF BUSINESS OR INDUSTRY Auto Mechanic		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS GROVE				14. MOTHER'S MAIDEN NAME MARY ANDERSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES UNKNOWN				16. SOCIAL SECURITY NO. 2-12-813921		17. INFORMANT admission Record.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E95 IX + 1530				CAUSE OF DEATH (A) DUE TO Hepatic coma. (B) DUE TO Serum Hepatitis (C) _____		INTERVAL BETWEEN ONSET AND DEATH 10 days unknown.	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>							
19A. DATE OF OPERATION April 1966		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cerebral Recurr.		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? none			
22. I certify that (I) (this hospital) attended the deceased from 9/22 1966 to 10/2 1966, that (I) (we) last saw the deceased alive on 10/2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Fred R. Silber M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/2/66	
23C. PHYSICIAN'S NAME (Type) Fred R. Silber M.D.				23D. ADDRESS University Hospital.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/5/66		24C. NAME of CEMETERY or CREMATORY LOUDON PARK		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1966		25B. NAME OF REGISTRAR Robert E. Farber, M.A.		25C. FUNERAL DIRECTOR E.S. MACNABB		ADDRESS 301 FREDERICK RD 21228	



1  
5-220

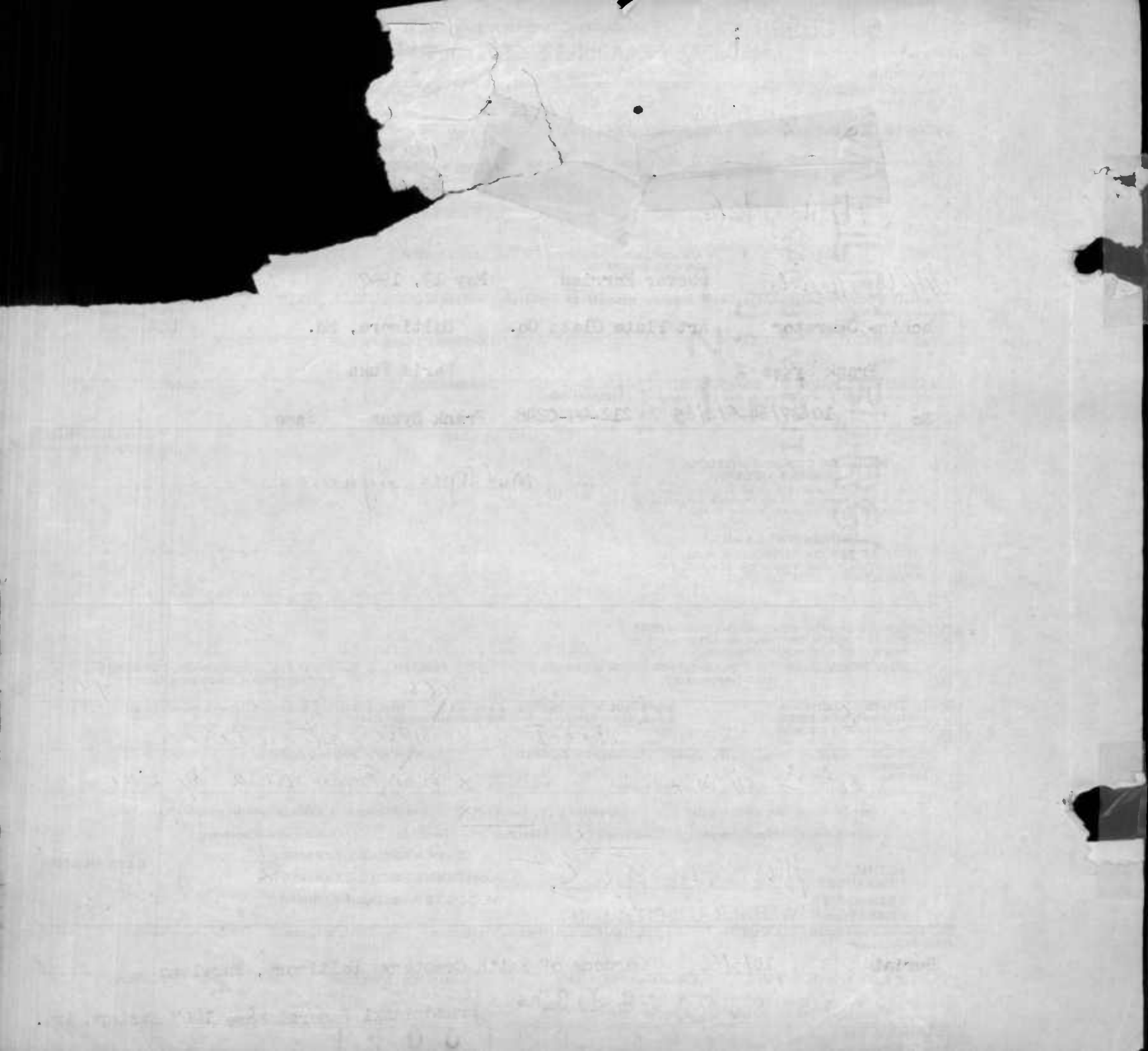
66 09998

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE	
Joseph F. SYKES		10	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN	
31 City Hospitals		Baltimore	
5. SEX		6. RACE	
Male		White	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Never Married		May 19, 1947	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
Machine Operator		Art Plate Glass Co.	
11. BIRTHPLACE (State or foreign country)		12. WHAT COUNTRY?	
Baltimore, Md.		USA	
13. FATHER'S NAME		4. MOTHER'S MAIDEN NAME	
Frank Sykes		Marie Fuka	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		212-44-0248	
17. INFORMANT		ADDRESS	
Frank Sykes		Same	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
(A) DUE TO		Multiple Injuries	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO	
		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2			
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		street	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?	
1800 Eastern Blvd.		pedestrian struck by car	
21E. TIME OF INJURY (APPROX.)		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour) Oct 2 6 200A		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER	
Werner U. Spitz, M.D.		<input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	
Burial		10/5/66	
23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Gardens of Faith Cemetery		Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	
OCT 5 1966		Robert E. Fawcett, M.D.	
24C. FUNERAL DIRECTOR		ADDRESS	
Brudzinski Funeral Home		1407 Eastern Ave.	

66 09998





# FUNERAL DIRECTOR: IMPORTANT

overed by the chief medical examiner or his assistant if death occurred in a hospital and by the chief medical examiner if death occurred elsewhere. Also, if the direct or contributing cause of death is not apparent, the physician who pronounced death was in regular attendance on the deceased prior to death. Such attendance should be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 099999		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 099999	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>WISSING, FREDERICK ADAM</b>		2. DATE AND HOUR OF DEATH <b>OCT. 4 - 66 10:05 AM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>26-02</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSPITAL</b>		(If not in hospital or institution, give street address or location) <b>33RD AND CALVERT ST., BALTIMORE, MD</b>		D. STREET ADDRESS (If rural, give location) <b>4210 SHAMROCK AVE.</b>	
5. SEX <b>M</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>01-31-12</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CAPT. FIRE DEPT.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>HERMAN WISSING</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH PAUL</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. EMILY WISSING-4210 SHAMROCK</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>420.1 I MYOCARDIAL INFARCTION</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>SEPT 17 ~ OCT 4</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>CONGESTIVE HEART FAILURE</b>		<b>SEPT 17 ~ OCT 4</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 17, 1966</b> to <b>OCT. 4, 1966</b> , and that (I) (we) last saw the deceased alive on <b>OCT. 4, 1966</b> and that in (my) (our) opinion death occurred on the date <b>OCT. 4, 1966</b> and from the causes stated above, (I) (We) (did) (did not) view the body after death.		23B. DATE SIGNED <b>OCT. 4, '66</b>	
M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23D. ADDRESS <b>15 E. Biddle St. #2</b>		24. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD</b>	
25C. FUNERAL DIRECTOR <b>ULLRICH FUNERAL HOME</b>		25D. ADDRESS <b>4210 BELAIR</b>			



Referred for psychiatric hospital

Oct 10

The above mentioned patient

33rd and Calvert St., Baltimore

and 33rd and Calvert Ave.

M WHITE

01-31-12

CPT. FRED DEPT

RECEIVED

HERMAN LUISIANT

ELIZABETH PAUL

Myocardial Infarction

Coronary Heart Disease

No

Oct 10

Sept 17

Oct 10

X

10 East Street

Oct 10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 10000</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 10000</b>	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>AUGUST HENRY WENERKA</b>			2. DATE AND HOUR OF DEATH <b>10/4/66 705 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore, Md. 2702</b>		
			D. STREET ADDRESS (If rural, give location) <b>3024 IONA TERRACE</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10-3-97</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired JEWELER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>JEWELRY Not Known</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			13. FATHER'S NAME <b>Adolf WENERKA</b>		
14. MOTHER'S MAIDEN NAME <b>Marie Richter</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, give war or dates of service) <b>YES Unknown WWI</b>		
16. SOCIAL SECURITY NO. <b>2-SECURITY NO. Not Known</b>			17. INFORMANT <b>Patient Chart</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>260X I Pulmonary Edema</b>			INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			CAUSE OF DEATH (A) <b>Pulmonary Edema</b> DUE TO (B) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO (C) <b>Diabetes Mellitus</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from <b>10-2-66</b> to <b>10-4-66</b> , that (B) (we) lost saw the deceased alive on <b>10-4-66</b> and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John R. Vaughn, Jr.</b>				23B. DATE SIGNED <b>10/4/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. JOHN R. VAUGHN, JR.</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>DURIAL</b>		24B. DATE <b>10/6/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>WOODEN PARK CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fairman</b>		25C. FUNERAL DIRECTOR <b>ULLRKH FUNERAL HOME 4210 BELAIR RD</b>			

DR. JOHN R. VIGOR, JR. MEMPHIS, TENN.